Spring 4-24-2019

Let Motherly Love Endure: An Investigation of Maternal Health in West Philadelphia

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Abstract
In 2000, the United Nations set forth its Millennium Developmental Goals, drawing attention to a worldwide epidemic of maternal mortality. This visibility facilitated global efforts to reduce maternal mortality and improve overall maternal health. Despite a successful reduction of 44% in the global maternal mortality rate, this progress was not seen by all members of the international community, especially the United States, reflecting numerous and diverse disparities related to healthcare access. In West Philadelphia, where the maternal mortality rate is as much as 1.5 times higher than the national average, the poor outcomes in maternal health in are a product of such disparities. This ethnographic study aims to investigate how maternal health is West Philadelphia is inhibited by barriers to access, looking at the challenges as well as the ways in which they are navigated. This thesis begins by analyzing the descriptive conceptualizations of maternal health that emerge from the women of West Philadelphia in comparison to normative ones given by biomedical discourse. The second section deconstructs this discrepancy, arguing that various barriers to healthcare access minimize the value and use of biomedical interventions. These barriers include, but are not limited to, poor urban infrastructure, finances, and characteristics of maternal health. The third section examines the social support system women in West Philadelphia create and rely on to navigate these barriers.

Keywords
infant and maternal health, West Philadelphia, maternal mortality, women's health, medical anthropology

Disciplines
Anthropology

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An Investigation of Maternal Health in West Philadelphia

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In

Anthropology

Submitted to the
Department of Anthropology
University of Pennsylvania

Thesis Advisors: Frances Barg and Adriana Petryna

2019

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Introduction: That Complex Object of Global Maternal Health

In his 2012 treatise, *That Obscure Object of Global Health,* Didier Fassin problematizes global health, citing that the broad nature of its characterization oversimplifies the inequities and inequalities which occur in more nuanced contexts. He argues that global health is obscure in its very definition translating to obscurity in its form, ambitions, and pursuit. This poses a challenge for not only medical anthropologists but also health workers, providers and patients, in varying localities, all of whom must negotiate their own consequences of global health's ambiguities. Fassin elaborates on this problematic obscurity through the terms which make up global health. Global, he believes, "unveil[s] the dialectic of spatial expansion and moral normalization," (Fassin, 2012) while health is emulative of the "tension between the worth of lives and the value of life," (Fassin, 2012). These tensions are compounded by those between the many players in global health from governments to non-profit organizations who interface with each other cooperatively or conflictingly. The reality is global health still has a long journey before it can be the cohesive and altruistic transnational force many hope for it to be. As it stands now, "most health issues and policies remain national and local," (Fassin, 2012).

In emphasizing this point of geo-sociopolitical characterization, Fassin draws on the ratification of the Affordable Care Act, explaining that despite the progress made in America's overall healthcare access, the bill omitted healthcare rights and recognition for the nation's tremendous population of illegal immigrants. This anecdote conveys state-oriented attitudes and conceptualizations of health shaping the globalization of health as a recognition of common goods whose access and utilization is challenged by varying local moral and political economies. When looking locally, one may find that such is the nature of health in the city of Philadelphia.

At a glance, Philadelphia's multiple world-class healthcare systems signal a pinnacle of care and innovation in health. This reputation belies the multiple public health crises the city faces. Philadelphia has high morbidities in diabetes, HIV/AIDS and poor environmental health. However, most concerning is the city's state of maternal health.

Philadelphia has one of the highest maternal mortality rates in the nation. According to the most recent data, in 2013, Philadelphia's maternal mortality rate was 53% higher than the national average at the time, 18 deaths per 100,000 live births. (Grizos & Weiner, 2015). Since then, the rate of maternal mortality in the United States has only increased to 26 deaths per 100,000 live births, in 2015, (Martin & Montagne, 2017). The United States suffers the worst maternal mortality rate in the developed world, despite being the biggest global spender on maternal healthcare (Cheng, Fowles, & Walker, 2006). The exacerbation of this problem in Philadelphia is only compounded by the fact that marginalized communities –socioeconomically disadvantaged, migrants, people of color- are disproportionately affected by these poor maternal health outcomes.

As such, maternal health in Philadelphia is emblematic of the tensions and disparities found in global health. As a microcosm of Fassin's problematization of global health, maternal health in Philadelphia precariously negotiates biomedical progress in care against democratized access for all, at the cost of the lives of women in the city who perhaps need this care the most. Overall, inequalities in maternal health outcomes are perpetuated by larger systemic inequities related to access and use of care and resources. Though often regarded as synonymous, inequality and inequity have a significant distinction on the global health agenda: "the former simply describes a difference between two measurements of the same indicator, while the latter includes the notion that this difference is unjust or wrong," (The Lancet Global, 2016). The

question of inequities and their impact on health experiences becomes central to my research as I investigate how individuals navigate and compensate for barriers to healthcare access and use, in the context of maternal health.

This thesis aims to offer insights into the inequalities of maternal health outcomes in West Philadelphia by analyzing the inequities which engender them and how these inequities are negotiated by those who still seek care and resources. I start by analyzing the descriptive understandings of maternal health that emerge from the patient realities of women of West Philadelphia in comparison to normative ones given by biomedical discourse. This juxtaposition demonstrates a local understanding and reality shaped by non-medical qualities of personal lives, which is vastly different from archetypal health expectations. The second section deconstructs this discrepancy, arguing that various barriers to healthcare access minimize the value and use of biomedical interventions. These barriers include, but are not limited to, poor urban infrastructure, finances, and characteristics of maternal health. The third section examines the social support system women in West Philadelphia create and rely on to navigate these barriers. This research is fielded from the experiences of the community's women. Through my interviews with them, I navigate an informal health system that services patients who reside in a city world-renowned for its health institutions, which they cannot access.

Background: The Global and Local Issue of Maternal Health

Maternal Health as a Question of Global Health

The World Health Organization describes maternal health as a woman's health during pregnancy, childbirth, and the postpartum period. However, maternal health is fundamentally difficult to distinguish from other categories of health. There are instances in which the intersection of maternal health is very familiar and clear, such as family planning or perinatal care. On the other hand, there are also instances in which such intersections are not the first to come to mind but still have major implications for maternal health such as intimate partner violence, infectious diseases and non-communicable diseases. Overall, there is a wide range of factors that can influence maternal health, in the same way that maternal health has far-reaching effects. The vast literature points to risks for poor maternal health that range from socioeconomic status to pre-existing medical conditions to geographical location (E. J. Brown, Grande, Barbu, Polsky, & Seymour, 2015; Center of Excellence in Maternal and Child Health, 2015; Say et al., 2014). Simultaneously, adverse maternal health outcomes are indicators for social mobility, infant health, and overall child outcomes.

A key measure for maternal health in public health is the maternal mortality rate (MMR). Maternal death is formally defined by the World Health Organization as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes," (World Health Organization, n.d.). Rates are computed by the number of deaths per 100,000 live births. Maternal death simultaneously informs ways in which maternal health care is lacking and can be improved. A

2014 WHO systemic analysis found that, globally, approximately 73% of maternal deaths were a result of obstetric causes –hemorrhaging being the cause for 27.1% of deaths- while the other 27% of deaths were from indirect causes which included, but were not limited to, comorbidities that exacerbated poor maternal health and suicide. The aforementioned, hemorrhaging and indirect causes, are top contributors to MMR that are closely followed by other obstetric causes: hypertension, sepsis, abortion, and embolism (Say et al., 2014) –a list that is far from exhaustive. Scholars often agree that a majority of these causes, especially obstetric causes, are highly preventable given the efficacy of their respective interventions. For example, hemorrhaging can be reduced or treated by ascertaining risk factors during the antenatal period, active management of the third stage of labor (AMTSL), and oxytocin (Evensen, Anderson, & Fontaine, 2017). However, the matter then becomes access to such interventions or preventative health measures, which would have negated the need for such interventions. Furthermore, 70% of these complications and mortalities occur after the mother has given birth, during the postpartum period (Krantz, 2015). This period of maternal health is largely neglected for concern of infant health. This neglect is manifested in the lack of structural support in maternal health from medical, financial and legal institutions during the postpartum period. This neglect is apparent during pregnancy and childbirth, but to a lesser degree, in the sense that maternal health is a means to an end for infant health (Montagne & Martin, 2017). This raises larger questions of global health inequities and complex power dynamics in health and health-related institutions that must be resolved in order to improve overall global maternal health.

The dangers to maternal health, in many places, may be more pronounced than others due to larger forces of structural violence. Although MMR and consequently, maternal health vary across the international community, they are universal health concerns. There is a common

understanding of the significance of maternal health that stems from its ubiquitous linkage to social determinants of health, various health concerns such as chronic or acute illnesses and other categories of health such as infant and family health. This uniting significance that maternal health wields gives it a unique potential to serve as a cohesive force in global health, as was recognized by the United Nations.

Maternal Health as a State Affair

In September 2000, the United Nations convened in New York City, New York and pushed forth the United Nations Millennium Declaration, a commitment amongst all 189 state members to work to address issues of poverty, hunger, violence, illiteracy and health. With the creation of 8 Millennium Development Goals (MDG) and respective markers to be reached by 2015, improving maternal health was number five on the list, with the specific targets of reducing the global MMR by 75% and providing universal access to birth control. Unfortunately, these goals have yet to be completely met, but progress has been made, though it is admittedly, "unequal and fragile," (WHO, 2018). In 2016, it was reported MMR globally had since declined by 44%, however, this trend of decrease was not seen by a number of countries, including the United States. In that period of global decline, the Center for Disease Control reports a sharp increase in the United States' MMR, which rose from "17 deaths per 100,000 in 1990 to 26 deaths per 100,000 in 2015," (Brait, 2015) despite its federal investments in the MDGs. It was also during this period that the United States was also the global leader in maternity care spending (Montagne & Martin, 2017).

Throughout the United States, MMR varies amongst differing geographic locations. While some states like California have managed to decrease its MMR to 7.3 deaths per 100,000

live births (Ollove, 2018), there are others which struggle against climbing rates. The state of Pennsylvania falls into the category of the latter. This past spring, governor Tom Wolf was prompted to pass legislation to install a state Maternal Mortality Review Committee in the face of a state MMR which has more than doubled between 1994 and 2015. In fact, this was not the most pressing concern, as the state's MMR has not been updated since 2015 (Buehler et al., 2015; Grizos & Weiner, 2015). And thus far, Philadelphia had been the only city in Pennsylvania to procure such information through a formal review process (Governor Tom Wolf, 2018). In early 2018, state legislators deemed this lack of formal data on such a serious public health problem as alarming, with implications that the state's MMR are likely much higher than initially thought, and current maternal health policies and programs are grossly uninformed and minimally impactful. The legislation, House Bill 1869 was introduced by Representative Ryan Mackenzie, who cited that its main purpose was to appoint a committee of at least 15 members composed of different healthcare experts and providers to investigate maternal deaths within the state, formulate and present their data and findings, and develop strategies to address the issue. Within 2 months of the bill passing, a committee, led by Pennsylvania's Secretary of Health, Dr. Rachel Levine, was swiftly appointed and sworn in, and on October 31, 2018, the committee had its first meeting at the Pennsylvania Department of Health in Harrisburg, Pennsylvania. The meeting welcomed remarks from Governor Wolf and Representative Mackenzie, a presentation from the CDC, and lengthy discussions and debate.

When I first began my research in 2017, the local conversation on maternal healthcare had a much different pace and tone than in late 2018-early 2019. It was definitely not a city government priority, let alone a state government priority. In December 2017, the Philadelphia Department of Public Health (PDPH) had just released its Strategic Health Plan for the years

2018-2021. The plan included strategic goals and markers that PDPH wanted to meet in order to work towards better overall health of the city. This was the second report of its kind that the city had only conceived of it in 2014. The PDPH published its first Strategic Health Plan, which was for the years 2014-2018 in May 2014, detailing 4 key health concerns that it wanted to prioritize and possible strategies to address them. Among them were sexual health, chronic diseases related to tobacco use and obesity, women's and infants' health, and environmental health, in order of importance. Although women's and infants' health were listed, strategies focused more on reproductive health access and education and infant immunizations. Though these are undeniably linked to maternal health, more explicit and relevant determinants of maternal health such as prenatal care were not addressed such as prenatal care. This plan came at the simultaneous publication of the PDPH's annual Community Health Assessment which noted the city's high rates of infant mortality and inadequate prenatal care access. Furthermore, despite the steady increase of these rates in the Community Health Assessments in the following years, the second Strategic Health Plan omitted any mention of women's or maternal health-related priorities.

Alongside this gap in consistent and constant conversation, the large discrepancy in maternal health data, which the new committee hopes to address, also played a vital role in shaping my research in 2017.[i] Prior to the formation of this committee, the existence of a Maternal Mortality Review committee in Pennsylvania has been limited to Philadelphia, but even then, its history is sparse and inconsistent. Established in 1927, the Committee on Maternal Welfare was formed by the Philadelphia Medical County Society in response to a discrepancy in maternal mortality data published by the federal and city governments. From then, it worked to provide insight into local causes of maternal mortality, significantly uncovering "self -induced and criminal abortions," (Buehler et al., 2015) as a major factor at the time. The committee

continued its investigative work into the 1970s, when it dissipated. The committee was marginally resurrected in 2006 out of the Maternal, Child and Family Health Department (MCFH) in the PDPH, but was disbanded in early 2008. In late 2010, the committee was recreated and conducted an in-depth investigation in 2013 into maternal deaths in Philadelphia from 2010 to 2012, publishing an alarming report in 2015. This report, which was later cited by a slew of news outlets, researchers, and healthcare providers alike, found that Philadelphia's MMR was 1.5 times the national average at 27.4 deaths per 100,000 live births. Apart from this report, there was only one other report published explicitly on maternal health, which was a 2009 evaluation of home-visiting programs on new mothers, by MCFH. These reports greatly represented the status quo of maternal health data in Philadelphia –heavily conflated with infant health data. Though the two are intrinsically linked, the latter was often on the forefront of the two and portrayed as the primary metric for gauging maternal health.

Consequently, the most consistent and recent data relating to infant and maternal health are the rates of 1). infant mortality, 2). low birthweight, 3). late or no prenatal care and 4). breastfeeding initiation before hospital discharge published every year in the PDPH's Community Health Assessment. Of these four categories, late or prenatal care provides the most direct insight into maternal health, speaking to accessibility and utility of maternal healthcare. The other three provide more information on infant health, but they can be potential indicators of maternal health, though not always. For example, infant mortality can occur even if the mother is considered to be in good health, due to completely external circumstances. Published reports from 2014-2017 have shown that high rates of these health concerns disproportionately affect people of color, as well as city planning districts with lower median incomes –which are often populated by people of color (Philadelphia Department of Public Health, 2014).

The most recent report published data from 2014 showing that black, non-Hispanic women and infants had the highest rates across the first three categories but scored the lowest in breastfeeding initiation. Hispanic women and infants had the second-highest rates for the first three categories and second-lowest for the last. Asian, non-Hispanic women and infants held the third-highest rates for the first three categories, but they had the highest rate for breastfeeding initiation. With the exception of breastfeeding initiation, white, non-Hispanic women had the lowest rates for all categories, however, their rates for breastfeeding initiation were comparable to those of Asian women. This overall trend was relatively consistent throughout all four reports for the first three categories and strongly reflected MMR published in the 2015 report, citing that black, non-Hispanic women made up 74% of all pregnancy-related deaths (Buehler et al., 2015). Furthermore, this trend strongly reflects those found in national data and data from other cities, respectively. For example, throughout the United States, black women are at least three times as likely to experience death from pregnancy than white women (National Partnership for Women & Families, 2018). However, in New York City, they are twelve times as likely (Hays, 2018). Despite the plethora of percentages and rates maternal mortality affords, these reports only marginally capture the issues underlying maternal health in Philadelphia and barely glean the frustrations and futility felt by women who confront these health experiences.

Maternal Health in West Philadelphia

West Philadelphia, in particular, is a meaningful place to study health disparities as it is an area of critical need for enhanced care delivery in underserved communities. However, two major universities contort the area's sociodemographic characteristics. A more in-depth analysis of the key neighborhoods[ii] targeted in this research project reveals an area that is

disproportionately affected by poor health outcomes. Data from the Household Health Survey conducted by the Public Health Management Corporation exposes alarming socioeconomic indicators which impact the health and access needs of West Philadelphia. The median household income in the targeted area is $21, 384 compared to Philadelphia's $34, 207. Approximately 43.7-62.7% of the population in the neighborhoods of this area is below the poverty level, compared to the city overall's 28.4%. Furthermore, the population is largely minority with 95% identifying as Black/African American and 1.8% as Hispanic/Latino. West Philadelphia is also home to a diverse immigrant community, with a large influx of peoples from North and West Africa and Pakistan occurring in the past 10 years (2015).

The same report cites that 18.1% of the population surveyed had no regular sources of care and 16.2% found cost as a barrier to seeking care in the last year. Issues of access are confirmed by a separate 2015 study conducted by the University of Pennsylvania, in which West Philadelphia was one of six clusters identified in the city with the lowest access to primary care, with a patient to provider ratio of 2055:1. This report explicitly linked minority status to poorer access, identifying that this cluster of low access, "overlaps with the areas of the city that have the largest Black population," (E. J. Brown et al., 2015).

For maternal health, which so heavily relies on preventative and active health, often facilitated by primary care, the consequences of these healthcare barriers become tenfold. The 2015 MMR report found that medical mismanagement was not the dominant cause of maternal mortality, but in fact, all but one death could be "traced to coordination of care, access issues and systemic inequities in healthcare and social service resources available to women during their prenatal and postnatal period," (Grizos & Weiner, 2015). The latest PDPH data shows that West Philadelphia struggles with some of highest inadequate prenatal care rates, with a range of 12.4-

21.4%, in Philadelphia (2017). More peripheral insights into maternal health in West Philadelphia are given by metrics of infant health. Low rates of breastfeeding initiation coupled with high rates of low birth weights and infant mortality in this area echo the disparity in maternal health data as well as the dire need for care and resources. Overall, poor maternal health in West Philadelphia is a multi-dimensional problem that suffers from extremely inadequate data, disparities between structural support in maternal and infant health, and challenging socioeconomic circumstances.

Furthermore, in West Philadelphia, alarming health statistics fuel vital local conversations regarding the racial disparity of maternal health outcomes. Throughout 2018, the Lucien Blackwell Branch Library held a discussion series entitled, "Why are Black Mothers and Babies Dying, and What Can We Do About It?" West Philadelphia, which is home to a number of the city's black mothers, is especially impacted by the maternal health crisis. That Black women made up 74% of the city's maternal deaths between 2010 and 2012 is only one of a multitude of the community's concerns. Though poor maternal health outcomes largely impact the black population below the poverty line (Buehler et al., 2015), it is a health issue which is perceived to transcend income levels among Black women. Pregnancy complications can occur from non-medical issues of Black women lacking access to culturally competent and responsive providers, gross underrepresentation of Black doctors, and environmental racism and embodied stress (Hays, 2018). In West Philadelphia, poor maternal health outcomes are a byproduct of various barriers to healthcare which intersect strongly with issues of race. Neither the barriers to healthcare nor issues of race are mutually exclusive, and thus, to consider the former without the latter, would be to discount the realities of mothers in West Philadelphia whose bodies are subjected to compounding forces of structural violence. Indeed, the presence of race across these

healthcare barriers demands comprehensive and equitable solutions in order to effectively address maternal health.

Methods

This intersectionality of maternal health drove me to pursue an ethnographic approach in my research. Though the topic of maternal mortality is one which has normally been tackled via a public health, epidemiological approach, I found that an ethnographic approach greatly expanded the reach of my investigation and better encapsulated this complex issue. This thesis spans approximately a year's worth of ethnographic work from summer 2017 to spring 2018. It began as an independent research project, with the help of the Undergraduate Research Fellowship granted by the Department of Anthropology. From May to mid-August 2017, I resided in West Philadelphia on the edge of the campus of the University of Pennsylvania. Initially, I planned to work out of the Sayre Health Center on 59th Street and Walnut Streets. However, in realizing that my research was to focus on healthcare disparity, I decided that interviewing patients who actively sought healthcare would be biased towards persons who already had a source of care. Emboldened by accuracy and the kind words of my one of my advisors, I sought to reformulate my approach. After a long search, I was fortunate enough to find a summer work-study funded job as a tutor at a local school in West Philadelphia, which enrolled students from pre-school to 8th grade all over West Philadelphia.

I was hired by the school principal, Mrs. B[iii], who became my initial gatekeeper. Throughout the summer, Mrs. B assigned me to assist in a kindergarten level reading and writing skills camp, alongside the teacher of the camp, Mrs. W, who became my principal gatekeeper. In many ways, she brokered many of the relationships I developed with the women I spoke to that summer, both intentionally and unintentionally. My summer tutoring position evolved into a classroom helper position during the school year, thanks to Mrs. W, who was also the school's kindergarten teacher and helped to facilitate my return during the school year. Though my

official job title was Tutor, I came during the school day and was a teacher's assistant for the kindergarten class though I was often shuffled around different lower grades, including 1st grade, and 2nd grade, as needed. On select days, I would stay afterschool and tutor 6-8th grade students in language arts and math, helping them with homework or school projects. I became known as Mrs. Cassandra, among administrative staff, teachers, and students, the prefix of Mrs. officiating my role and presence in this community. Through my tutoring and teaching interactions, I built relationships with both teachers and students that eased very well into relationships with parents and/or guardians. Working alongside Mrs. W, I had the fortune of meeting countless dynamic and wonderful women and mothers who went on to later become my informants. However, I did not enter this space as a researcher nor did I ever prioritize my identity as an anthropologist. I sought to prioritize providing my time and services as a tutor and a teacher's assistant to the best of my ability and pursing my research secondarily. It was not until much later in the summer, when I felt was appropriate, that I shared my research interests and my project. In retrospect, doing as such worked in my benefit in the long-term, as those I interviewed later thought of me still as a tutor or teacher's assistant, and my research as an extension of the investment I had in the community, less so as a student's intellectual pursuit.

Though Mrs. B and Mrs. W introduced me to other community spaces in West Philadelphia, such as beauty salons and church ministries where I also conducted fieldwork, the bulk of this thesis focuses on the data obtained in the space of the school. Participant observation and semi-structured interviews were principal methods I employed, however informal conversations often gave way to new data as well. Collectively, these methods provided valuable insight into the experiences of motherhood and maternal health that were not illustrated by the city's quantitative data.

The bulk of my participant observation took place in the school, as I was essentially a teacher's assistant. During the summer and school year, I assisted Mrs. W with classroom activities and student pick-up, waiting outside with students until their parents picked them up. During the school day, I would often listen to teachers discuss their personal lives outside of the school. This included stories they had about their own children or experiences as a mother. While waiting with students during pick-up, I would also briefly talk to parents, especially mothers, about their days or their children. During after-school tutoring hours, I assisted other teachers in tutoring students as well as Mrs. B with some administrative tasks. These were also moments of conversation that I found useful to my research. I took field notes intermittently throughout the day, during breaks, but I recorded field notes and day summaries at the end of the day, once returning home. These interactions afforded me great opportunities to build relationships within the space of the school that later allowed me to expand my research to other spaces in the neighborhood. I conducted a total of thirty-two semi-structured interviews, using a guiding list of topics that included questions I wanted to address but at the pace of the interviewee. I used a snowball sampling technique in order to recruit participants at the school and beyond the scope of the school. Ultimately, this proved to be only marginally productive as logistics were very difficult to coordinate most of the time. There were only two interviews which I conducted outside of the school. One took place in a local hair salon, and the other took place in a local nail salon. The thirty other interviews took place at the school or at a local park near the school. With the exception of the interviews in the beauty salons, all other interviews were held in semi-private spaces, where the conversation was predominantly between the interviewee and myself. All of the interviews were conducted with women who were between the ages 22 and 67.

Before every interview, I asked for verbal consent for participation and interview recording. I also informed participants that they could refrain from answering any questions they did not feel comfortable with and that the recording could be stopped at any time, if they consented to being recorded. Following all interviews, I debriefed every participant more thoroughly on my project to practice complete transparency and I encouraged them to pose any further questions or provide any further comments if any should arise in the future. All interview locations were ultimately chosen by the participant as places they felt the most comfortable speaking. The interviews averaged about thirty-five minutes in length and were conducted in English. English was the second language of only a few participants, as West Philadelphia is home to a diverse array of immigrants from North and West Africa, the Caribbean and Asia, however this did not act as a barrier to data collection. All interviews were recorded on a handheld recording device. The audio files were uploaded to a secure computer drive and transcribed onto a Word Document before they were uploaded to NVivo 11. The transcripts were initially deductively coded based on the topics and themes from my interview guide. As I went along the coding process, other implicit themes arose, and so I went back and inductively coded select interviews. These coded themes or nodes are discussed in the following chapters.

Researcher Positionality

Throughout the duration of this project, there were many parts of my identity and privileges which I had to reconcile. My student affiliation with the University of Pennsylvania was both a good and bad thing. I received many comments and anecdotes about Penn, as I was often seen as an extension of Penn. Depending on the participant, I was emulative of a certain characteristic. For example, there were participants who were vocal about the university's tense

relationship and complicated history with the West Philadelphia community, wary of Penn's notorious gentrification and wealth. On the other hand, there were many participants who lauded Penn's reputation as a prestigious Ivy League. Both negative and positive impressions of Penn were also formulated from previous experiences with health services within Penn Medicine, such as going to a Penn affiliated hospital Emergency Room. Furthermore, as an Asian-American, in a predominantly black space, I was very much an outsider. However, many interviewees perceived me as an insider due to my non-whiteness and my experiences of growing up in South and East Los Angeles[iv]. Some were very comfortable bringing matters of race, against white American culture, and were excited to share relatable experiences from attending an inner-city high school to navigating microaggressions. Regarding positionality, I understand all these personal characteristics may have affected my interviews, observations, and interactions with my informants. I also understand that as a non-black individual, it is not my place to evaluate the validity of my informants' experiences, appropriate their narratives, or speak on their behalf without their consent. Rather I can only relay their stories and recognize the challenges which they face, without diminishing their grievances. Finally, the most principal examination of my positionality and privilege was understanding the way in which I was leveraging my tutoring services, elevated by my Penn affiliation and ethnic identity, to access this community and information. It was important for me to understand that education, which is often regarded as an equalizer, must be recognized for all its inequities, imbalances, and inclinations, as well. To fail to acknowledge this was to normalize marginalizing institutional forces.

Section I: Perspectives of Maternal Health -Disparities in Expectations and Realities

In this section, I compare normative understandings of maternal health shaped by biomedical discourse and descriptive experiences of patients in West Philadelphia. I discuss literature and provider understandings of maternal health which are largely shaped by biomedical processes. I compare this to the local understandings of what? which are predominantly characterized by social support and acute self-awareness. I demonstrate that there is a lack of structural support for maternal health –which is often seen more, as a means to an end for infant health- that inhibits women from receiving appropriate care they need.

Provider Expectations of Maternal Health

Maternal health is understood as a woman's health through the periods of pregnancy, childbirth and the postpartum period (World Health Organization, n.d.). Within each period, health is facilitated through distinct preventative or active interventions, and care can be delivered by various healthcare professionals, including a family physician, obstetrician, OB-GYN, or midwife. For a healthy pregnancy, prenatal care is considered crucial for both maternal and infant health and should be sought out as soon as a woman thinks she may be pregnant. Prenatal care is a form of preventative healthcare. The first prenatal visit should be the longest, due to the volume of tasks which must be completed (American Pregnancy Association, 2012). In this visit, the provider is expected to go over the mother's medical history, conduct a physical exam, do various blood tests, inform the mother of what to expect throughout her pregnancy, and address any questions or concerns the mother may have. Consecutive prenatal visits serve as a way to monitor the growth of the fetus and the mother's physical health. Any complications or

risks which arise can be addressed with prenatal therapies including vaccinations, vitamins and supplements, or physical therapy. A typical prenatal visit schedule includes monthly visits before 28 weeks –with the first visit ideally being scheduled after the 8th week of pregnancy, biweekly visits from weeks 28 to 36, and weekly visits following 36 weeks of the pregnancy until birth (NIH Office of Communications, n.d.). This schedule and care do vary based on the level of risk associated with the pregnancy, i.e., if it is high risk. Maintaining maternal health becomes a more dynamic process when the mother goes into labor. A safe delivery for the mother and a healthy baby is facilitated by labor monitoring and pain management. Monitoring is done with a partograph, after taking in the patient's labor history. This tracks the progression of the labor, allowing providers to spot abnormalities such as slow rate of labor, and address them actively (Oladapo et al., 2017). This in conjunction with pain management guides the distribution of pharmaceutical therapies such as epidurals or other pain medications to help the mother. Following the birth of the child, maternal health during the postpartum period is monitored via a maternal check-up 6 weeks after giving birth, usually entailing a physical and psychological exam (Cheng et al., 2006).

Generally, good maternal health outcomes are understood as a product of adherence to these care regimens and standards (ACOG,2018). These processes and treatments are designed to facilitate health by preventing or reducing risk, underscoring an anticipatory attitude that mainly emphasizes the pregnancy and delivery periods of maternal health. However, this medicalization of maternal health and care which represents the wide consensus of academic discourse of maternal health, often differs with that of emic, patient perspectives. A patient's understanding of health and care largely influences the patient's operationalization of health and care (Tinago et al., 2018). Numerous studies have uncovered local understandings of pregnancy and

motherhood, using them to inform more socioeconomic, behavioral, or biomedical interventions for better maternal health outcomes. For example, a study conducted in Honduras on perceived vulnerabilities to motherhood identified witchcraft stemming from jealousy and anger fueled by socioeconomic disparities, as a threat (Arps, 2009). Thus, recommendations were made for more conscious and equitable distribution of non-profit and governmental health resources and services (Arps, 2009). Overall, a woman's conceptualization of pregnancy, motherhood, and especially, maternal health informs her health decisions before, during, and after pregnancy (Tinago et al., 2018), underscoring the significance of understanding local conceptualizations.

Patient Realities of Maternal Health

Mrs. W was the first mother I met in West Philadelphia –the first grandmother, in fact. True to her grandmotherly nature, she loved imparting life advice on me, bringing me baked goods, and sharing her adventurous tales of grandmotherhood with me. Whenever I asked about her weekend or evening, she would dramatically narrate her grandson's destruction of her tidy kitchen and her granddaughter's latest one-woman show. After about a month of working at the summer camp, Mrs. W introduced me to her daughter Mrs. J, who, like her mother, talked ardently, at the mention of her children. From their stories, and later, those of others, it becomes clear that motherhood is an experience that is earnestly shared.

In West Philadelphia, the maternal experience is as much an individual experience as it a collective one, in all its matters –challenges, victories, and most relevantly, health. A positive pregnancy test is a lives-changing moment. It impacts a woman's life and that of other individuals who are a part of her own life. Throughout my time in West Philadelphia, I met women who were each at varying time points relative to the moment of the positive pregnancy

test. Whether it was three-months or three decades after, their narratives gleaned the sociality of the maternal health experience –a quality which greatly facilitated my research efforts as I became a part of the community. Though Mrs. W was the first mother I met, her daughter was the first mother I interviewed. In retrospect, this was rather fitting as I had spent much of my time in West Philadelphia working alongside Mrs. W.

As her two children ran around the playground of a local park near the school, Mrs. J told me about her first pregnancy. After getting married and buying a house 7 years ago, she and her husband decided it was time to have children and had been trying to get pregnant for a few months, without avail, until a fateful day in May when she decided to take a pregnancy test after missing her period. She relayed to me the rush of emotions she felt –intense joy, fear, and excitement- take her over as her hands shook, holding the positive pregnancy test. She recalled rushing out of her bathroom to call her parents –her mother, Mrs. W, screaming in excitement over the phone about having her first grandchild. Her husband was over the moon with the news, as well as her best friend, who along with her then boyfriend, and now husband, later agreed to be the soon-to-be baby's godparents.

In the year that followed, Mrs. J included several other people in her pregnancy and transition into motherhood, all of whom helped her in one way or another. Most of those people stood around her hospital bedside, after she gave birth.

> "I just remember, in the hospital, when everyone was standing around me and my baby girl, I could feel it you know. It was light and beautiful, my man was crying and my momma couldn't stop smiling. There was just so much love that I felt and took in. I was so tired and exhausted, but just feeling that love made me feel better –it made me feel so alive." (Interview, June 2017)

This narrative conveys the both the personal and social nature of the maternal experience, in which maternal health is configured by the mother, and social support systems are directly

linked maternal health, respectively. Mrs. J's self-gauging of her physical health conveys that maternal health is very literally the health of the mother, regardless of her pregnancy status, as shown later by other informants. It is the mother who ultimately recognizes and regulates her personal well-being. With respect to the social nature, the events of pregnancy and childbirth have a ripple effect which moves outward from the mother and ripples across her social circle. The emotional solidarity of this experience becomes foundational to the existence and quality of the mother's social support system during and after her pregnancy. Mrs. J generously credits her health and that of all her children to her loved ones, who "kept me in their hearts and prayers. They asked God to keep me and my baby safe. They always checked up on me –made sure I was doing all right and handling everything okay." (Interview, June 2017). This narrative conveys how maternal health outcomes are perceived more as a product of collective efforts to socially and emotionally support the mother through pregnancy, childbirth and the postpartum period, as opposed to monitoring or medically treating her. Many informants shared the sentiment that the more collective the investment in the pregnancy, the better it is for the mother.

Informants describe a social support system that is multi-layered network and hierarchal in terms of familiarity and benefit to the mother. The mother is at the center of this network. Each outer layer is a cohort of people, whose perceived relations to the mother and importance to health decreases moving outward. The first layer surrounding the core is the immediate family. This includes parents, siblings, and spouse and/or partner of the pregnant mother. Moving outwards, following immediate family are other relatives such as aunts, uncles or cousins and close girlfriends, such as childhood friends. The next layer of the network is composed of social friends, a category which came to include neighbors, co-workers, and family friends. These were individuals that informants described as having regular, almost daily interactions with and "good

relationships." The next layer is composed of community members, a broad term for individuals that informants interacted with semi-regularly and had standing personal relationships with. This included a range of people from teachers of their children to regular beauty stylists to pastors. Interestingly, the most peripheral layer of this network is occupied by healthcare providers, even those that the informants saw on a recurring basis. Though this was the general organization of the network, it varied amongst some informants.

For example, Mrs. Z, a single mom whose parents passed away from cancer when she was a teenager, expressed that she finds her greatest support from her aunt and cousin. Not only does she live with them, but her cousin is a nurse practitioner who provides her, along with most of her relatives, medical advice. In this case, for Mrs. Z, the link between her health and support system is more apparent. That her network is not as expansive as Mrs. J's but still provides enough support for her conveys the idea that the perceived quality of the support trumps its quantity.

> "It's hard being a single mom, but I know it would be harder if I was by myself, alone. I really don't know what I would have done if I didn't have [Cousin]…I don't know. I think it's important for single moms to have family and friends we can rely on." (Interview, June 2017)

Like Mrs. J and Mrs. Z, many other informants named different people who they deemed provided support throughout the duration of their pregnancy and motherhood, thus far. The quality of social support has often been linked to pregnancy outcomes, and overall maternal health outcomes (Abdollahpour & Keramat, 2016; S. Abdollahpour, Ramezani, & Khosravi, 2015; Balaji et al., 2007; Izadirad, Niknami, Zareban, & Hidarnia, 2017; Tani & Castagna, 2016). Social support can emerge "in various forms of physical, emotional (sympathy, love, and care), verbal and financial assistance," (S. Abdollahpour et al., 2015) from different individuals.

Many women shared warm stories of friends or families cooking meals, providing child care, and donating extra baby supplies during their pregnancies. Such contributions, which were ultimately non-medical, were appreciated by informants as beneficial to their overall well-being.

In this way, maternal health in West Philadelphia is understood as largely social and comparatively less medicalized. These themes are reflected in Arps' findings in the Honduras, in which pregnancy risks were seen as non-medical, social threats from non-provider individuals like strangers or neighbors (Arps, 2009). And although, these local understanding and approaches to maternal health in West Philadelphia may not align with biomedical conventions, this is not to say they are harmful by any means. In fact, there is an overall democratization of the maternal experience. For informants, this makes resources and help seem more accessible. Social engagement has been show to "positively influence maternal-child health knowledge regardless of socio-economic factors," (Prusty & Unisa, 2017). It also makes better outcomes seem more achievable. These perceptions underscore the authority which informants take over their own maternal health. Such is the case that in West Philadelphia, maternal health is not just confined to health during the perinatal period but is thought of as overall well-being. The demedicalization of maternal health lends the mother more agency in her pursuit of her health.

Infant Health Above Maternal Health

Indeed, maternal health is medicalized as a means to an end for facilitating infant health (Montagne & Martin, 2017). While the mother does receive attention and care, this is principally done in the interest of the infant's well-being. This attitude is not only reflected in biomedical processes but emerges in social and legal dimensions. Certain types of mothers are posited as antagonistic to their own children or child to be, such as those who are "older" (Jarvie, Letherby,

& Stenhouse, 2015) , “criminal” (Singh, 2017) , or “poor” (Cammett, 2016). The notion of the Other mother, one who is deemed unhealthy or unfit emulates the regulation exercised over female bodies via the unborn fetus, even before pregnancy. During pregnancy, at the height of a mother’s engagement with biomedical processes, the mother’s body is subjected to examination and therapies, such as blood tests, ultrasounds, and C-sections, for the sake of ensuring the health of her child, especially during the prenatal period and labor. “The baby is the candy, the mom is the wrapper. And once the candy is out of the wrapper, the wrapper is cast aside,” Dr. Alison Stuebe, a professor in the Department of Obstetrics and Gynecology at the University of North Carolina School of Medicine, uses this metaphor to describe this prioritization in an interview with NPR (Martin, 2018).

A number of maternal health experts agree with Stuebe’s sentiments, asserting that there is an underwhelming focus on the health of the mother, compared to the infant, considering that most maternal deaths occur after childbirth (Krantz, 2015; Martin, 2018; Montagne & Martin, 2017). The consequences of this focus create a feedback loop, with attention to maternal health greatly diminishing in policy, research, and healthcare because of the shift away from attention which has already occurred. This is embodied by the stark contrast between national trends in rates of infant mortality which are at a historic low (Brait, 2015), in comparison to those of maternal mortality which have seen a steady increase. In Philadelphia, data published by the PDPH, consistently reports on infant health outcomes every year whereas there is a gaping disparity in maternal health data, which has not been collected since 2013 and reported since 2015. In terms of care, it is often more likely that a mother will receive better and more consistent prenatal care than postpartum care, when mothers perhaps need care the most (Krantz, 2015; Montagne & Martin, 2017). In fact, most healthcare plans only cover a single postpartum

visit that must occur within six weeks of childbirth, compared to multiple prenatal care visits. According to the American College of Obstetricians and Gynecologists, approximately 40% of new mothers, "overwhelmed with caring for an infant and often lacking in maternity leave, child care, transportation and other kinds of support never go back for their follow-up appointments," (ACOG, 2018).

Mrs. R, a mother of two, recalls the period after last pregnancy being difficult to manage as she tried to balance recovering from her C-section and going back to her daily life.

> "I was in the hospital for an extra four days, and all I wanted to do was get back to being me, you know. I'm just like that I think. I always feel like I need to be moving –doing work. But my nurse, said what I was feeling was normal, because I was a mother –mothers are always worrying about something. She also told me, "C-Sections are the only surgery I know where the patient is expected to convalesce immediately AND take care of someone else." [Laughs]. Moms always have to do everything, that's just the way it is." (Interview, July 2017)

As the narrative conveys, despite these caveats, maternal responsibility for infant health trumps maternal health. The responsibility is two parts; external societal expectations as well as a mother's individual sense of responsibility work synergistically to further elevate infant health, once she is discharged from the hospital. Comparatively, maternal health does not possess these same pillars of support. Thus, for Mrs. R there is a complex tension in maternal responsibility empowerment to care for her child but at the cost of her physical health, following a C-section. For women who undergo this procedure, the postpartum period can be especially risky and strenuous for both physical and mental health, necessitating supplemental care. Generally, in addition to 3 or 4 extra days in the hospital, it takes 6 weeks for the body to completely heal, given that there are no complications (ACOG, 2018).

> "The doctor told me it would take at least 6 weeks for me to make a full recovery, but I went back to work after 5 –I was lucky I had a nice supervisor, she was a mom, so she understood what I went through, you know. She had helped

> me with paperwork for maternity leave. But I didn't end up qualifying for FMLA[v], so she had let me work part-time from home so I could take care of my baby. But I could only do that for a month, because I –the FMLA- I didn't qualify. I got really lucky, but it was still hard." (Interview, July 2017)

Her shortened recovery time demonstrates the de-emphasis of her own health in the interest of her child, job security, and finances. And although, she did report completing a postpartum check up at the 6-week mark, she did not return for regular check-ups, citing insurance coverage and her work schedule as an issue. Though, she describes these as choices of her own, there are underlying systemic forces which more coerce, than facilitate this decision.

In more ways than one, normative discourse presents a type of maternal health conceived in a vacuum, one which neither considers nor acknowledges economic or social stressors, faced by countless women, especially those in West Philadelphia. In an area, where much of the population faces poverty, socioeconomic stressors are disproportionately magnified. And as shown by Mrs. R, addressing these stressors can come at the cost of maternal health. Compounding these financial concerns are unpaid maternity leave and poor job protection during maternity leave. The normalization of these practices, which are byproducts of legal institutions, reify the feedback loop of neglect of maternal health. Mrs. R's acknowledgement of her "luck" strongly reflects the institutionalization of the maternal disregard as she admits to being the exception to the status quo. Furthermore, that she was afforded the opportunity to work part-time and remotely was more for the sake of Mrs. R's newborn infant, than was for her to recover from her surgery –" she had let me work part-time from home so I could take care of my baby" (Interview, July 2017). The construction of maternal responsibility in infant care is a result of the potentiating structural forces of legal and financial institutions to neglect maternal compensations (i.e. maternity leave and postpartum coverage, respectively). Thus, systemic

disregard for maternal health becomes a hegemonic force that excludes mothers from the healthcare system, as care becomes fragmented and resources, inaccessible.

Section II: Barriers to Care -Challenges Affecting General and Maternal Health

In this chapter, I argue that there are additional causes which adversely affect maternal health, by inhibiting access to the healthcare system amongst women in West Philadelphia. I analyze barriers stemming from urban planning, affordability, and the institutional character of the healthcare system, itself, among many others, which constrain the mobility and authority of health-seeking behaviors of women in West Philadelphia. With respect to urban planning and affordability, I demonstrate that these are barriers to health overall, as "maternal health care services have to be contextualized within the broader comprehensive primary health care approach," (World Health Organization, n.d.) to fully address social determinants of maternal health. However, in analyzing the healthcare system, I specifically contextualize it, within maternal health, to point out nuanced, systemic issues that are otherwise overlooked.

Getting Physical

Within the area of West Philadelphia that I confined my research, there are 8 healthcare facilities: 2 behavioral health centers, 3 primary care practices, 1 pediatric primary care center, 1 hospital, and 1 women's clinic which was associated with the hospital. I visited each health center's website and called their offices in order to inquire about the availability and capacity for maternal health care. Of the eight sites, only the last two have women's health specialists such as obstetricians or gynecologists on staff. Aside from the behavioral health centers and the pediatric primary care center, all other sites have family physicians on staff who are able to assist in prenatal and postpartum care. When asked about delivering babies, the non-hospital sites indicated that the patient would be referred to a hospital, where the attending physician during

labor, would likely not be the patient's doctor during prenatal or postpartum care. Furthermore, patients with high-risk pregnancies were often provided various outpatient referrals to maternal health specialists at the local hospital, Mercy Hospital or Penn-affiliated Hospitals. Thus, overall, there are only really 5 health facilities in the area that can provide some form of maternal health services, but only 1 can do so comprehensively. These limited opportunities for healthcare access

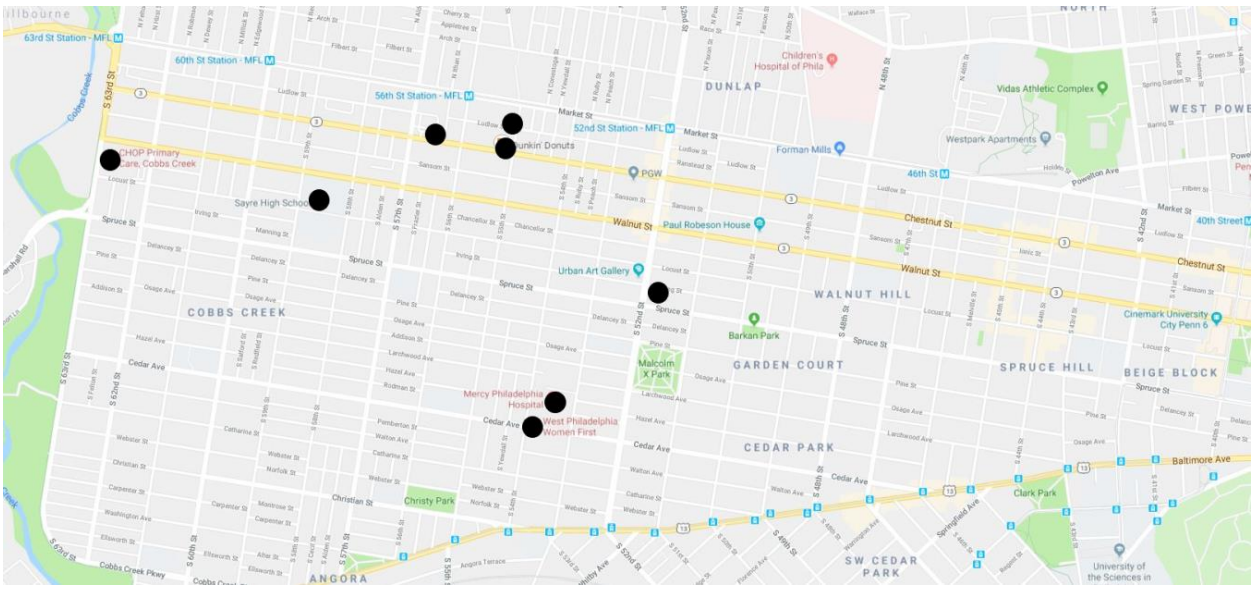

Figure 2.1 The map shows an area of West Philadelphia relevant to the study. Each black circle denotes a health facility, mentioned above. Mercy Hospital and its affiliate women's clinic are labeled, as well as the pediatric primary care center. *Dinh, Cassandra.*

reflect the low provider to patient ratio in West Philadelphia found in the 2015 University of Pennsylvania study mentioned earlier.

However, the ability to physically access these limited health services is an entirely new concern. Informants cited various means of transportation they used to go to healthcare facilities including a personal car or bike, Uber or Lyft, SEPTA, and simply, walking. Few informants used private transportation regularly, but all, at one point, had used SEPTA the public transportation system of Philadelphia, which runs throughout the city via rail, trolley, and bus networks. For the most part, all 8 of the healthcare facilities are located along a SEPTA route or

at least within a couple blocks of one, ideally facilitating public access to such facilities. Though the bulk of SEPTA runs through downtown Philadelphia, there is only 1 rail line (Market-Frankford) and 4 bus lines (21, 42, 46, G) which run throughout West Philadelphia.

When comparing SEPTA routes between University City and greater West Philadelphia. The former, which covers a smaller area has a higher density of transit routes intersecting through it –a route is found at almost every two blocks moving east to west, and north to south. In West Philadelphia, which spans a region at least three times as large as University City, possesses only a fraction of its transit density. This disparity in transit density is alarming because of the role that public transportation plays in health. In Philadelphia, many patients rely on public transit to access care, "especially those of lower socioeconomic status," (E. J. Brown et al., 2015). Thus, such a disparity would be especially harmful for the health of communities like West Philadelphia, which already face issues of limited care and resources.

Figure 2.2 This is a map of the SEPTA routes which are shown to run through parts of West Philadelphia. *SEPTA Philadelphia Network Map*

For those that rely on SEPTA for their transportation, these routes dictate which health services they can and cannot access. Mrs. A, who lives along the rail line but none of the bus

lines, is one of the few informants who do not utilize any of the 8 healthcare centers. She tells me, "I just take the MFL to 40th and walk myself over to the Penn Hospital there. My friend prefers Mercy because she says the people there are nicer and the wait is shorter." (Interview, July 2017). The MFL, or the Market-Frankford Line (shown as blue in Figure X) is one of the few SEPTA routes which runs through West Philadelphia. It is the only rail route, and it is located along the north boundary of the neighborhood. It is a convenient way to access the city and has two major hospitals and numerous health offices affiliated with Penn located along its route. Thus, it is a major boon for those who can access it. In the same way, those that can access and utilize the bus routes in West Philadelphia are able to access these health centers.

> "I don't really know about Mercy, because I've never been. Wait no, I think I've been once, to visit my friend. Yea. I don't go to Mercy because it's just easier for me to take the MFL. For me to go to Mercy –I did this last time. I would have to get off the MFL at 52nd to take a bus and then go a block… yeah… yeah…I think I did that last time. But yeah, it's just easier to just stay on the MFL 'cause it's a straight shot and I live by it." (Interview, July 2017)

Although, the MFL does offer transfer stops for some of the bus lines and thus, access to these centers, it is rather time-consuming and costs extra to navigate between the transit lines. For Mrs. A, these are barriers enough to deter her from straying from the MFL. In the same way, other informants who used buses as their primary form of transportation shared similar experiences of preferring to visit health centers that were on their respective bus routes. For example, Mercy Hospital, which rests a block away from the 52 and two blocks away from the G, is a popular option for many patients, including Mrs. A's friend. However, these transit routes are not widely accessible throughout West Philadelphia, especially in areas they are perhaps most needed. Below Spruce Street, in the southwest corridor of West Philadelphia, there are no health centers and here, only two of the four bus lines run. They cover a minimal radius as they each follow a straight path going between north and south, meaning that there are those who

must walk to a route, if they want to access it. Geographical constraints on access fuel further exclusion from the healthcare system, as patients not only struggle to find, but physically reach providers.

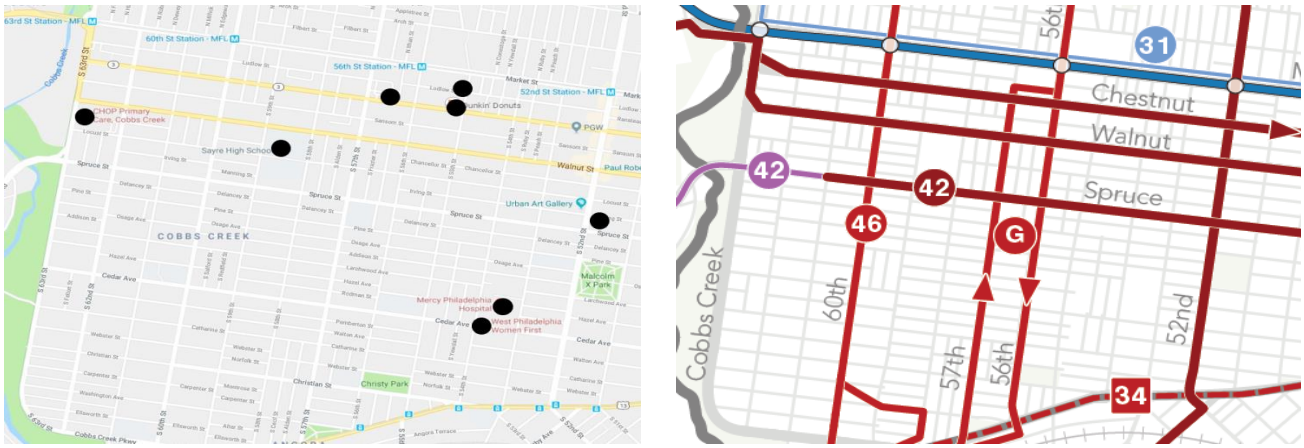

Figure 2.3 This is a side by side comparison of the western portion of the two previous maps. Below Spruce Street, there are few transit routes and no health facilities, effectively creating a healthcare dessert. *Dinh, Cassandra*

Walking and waiting for transit is a common experience among informants, but it is one that becomes very difficult during the fall and winter seasons. Informants brought up issues with the cold weather, early sunset, and rainfall, which often deterred them from walking and waiting unless very necessary, such as for work. Mrs. W, who has used the bus to get to and from the school every morning for the past 7 years, describes her loyalty to SEPTA and its utility in her life.

> "I've been using SEPTA since before you were born. I used to take it all over Philadelphia –into the suburbs, and to Jersey…I use it to come here [to the school]. I use it to go see my family. I use it to go buy groceries…and my meds. I use it to take my grandson to the Y in the summer and the library, too."
> (Interview, August 2017)

Mrs. W's praise of SEPTA is undergirded by her strong reliance on it. Her narrative makes a critical point that limited walkability and transit infrastructure affect health in other

ways besides access to health services. For example, a healthy diet can be difficult to maintain if access to healthy foods is limited. A report by the Urban League of Philadelphia, on the state of the black community in the city found that "three times as many blacks have difficulty locating fresh produce in their neighborhoods as do whites [with] 40% travel[ing] outside of their neighborhood just to get to a supermarket, compared to 27% of whites," (Anderson et al., 2013). In addition to grocery stores, being able to go to pharmacies and community spaces is also vital to one's overall health, with respect to nutrition, wellness and social support. These three things are especially vital to the culture of maternal health in the West Philadelphia community, as demonstrated in the following chapter. However, those who rely on public transit with lengthy routes, irregular service or the inability to pay for transit are at an increased risk of foregoing needed health services and resources (Melton, 2017). Thus, poor urban planning inherently affects maternal health because of its impact across more general dimensions of health.

Absence of Affordability

The quality of affordability takes on many dimensions among informants, being described in terms of one's finances, time, and value relative to health condition. Affordability acts as a metric of regulating perceived healthcare need, measuring the cost of self-management against that of seeking external resources and care. The defining characteristic of affordability is the trade-off, sacrificing one thing, in this case, health, to preserve another: money, time, or the firm belief that everything is "fine."

Finances

"Being a mother is expensive," Mrs. W remarked, one day afterschool. It was her daughter's birthday, and she showed a couple of parents and me, the matching sundresses she bought online for her daughter and granddaughter, clicking her tongue. "Being pregnant is expensive," Mrs. P counters to Mrs. W's remark. All the women laugh, empathizing strongly. When I interview Mrs. P later, she laments about the costs from her first pregnancy.

> "It all kind of just adds up –all those doctor visits. After the first one, I had to pay $50, and I was just like, what??! That's like $50 I can use to buy groceries. I can't be spending an extra $50 every couple of weeks, when I gotta pay bills and eat. Also, you know, me eating, is probably more important for the baby anyway. That's just better, to eat good, you know, instead of not eating enough and then going to the doctor who will be like you need to eat, but I can't because I'm paying the doctor. It didn't make sense, is what I was thinking." (Interview, August 2017)

Her rationale in weighing healthcare and other costs is shared by several other mothers I interviewed. In general, low financial affordability was cited as a barrier to health, as a majority of informants discussed high costs surrounding transportation, health services, pharmaceutical therapies, and insurance. Specific to maternal health, for some mothers, like Mrs. P, these costs inhibited adequate prenatal and postpartum care. Whether it was forgoing check-ups, rationing prenatal vitamins and other medications, or opting for less expensive and less available providers, many mothers were aware of the potential implications of their decisions to cut costs.

Though no one was asked to or chose to disclose their financial ability, comments about "not making enough,", "just getting by", "working more than one job" undergirded common experiences of picking and choosing between different living costs, healthcare being one of them. Mrs. P, who chose to spend her money on groceries during her first pregnancy, sought out prenatal care from a Planned Parenthood clinic. She was not charged for her visits, but the clinic

was on the other side of the city. However, since becoming pregnant again, her financial situation has significantly changed, allowing her to enroll in better insurance and pursue better healthcare. Three months pregnant, with her second child, Mrs. P regularly goes to prenatal visits at a local private practice, closer to home. She reflected on the differences between her first two pregnancies, in terms of access to care, noting how her perception of affordability in relation to health has also changed.

> "It's easier this time around to process everything, maybe it's because I've done it before. But I feel more prepared this time –less anxious about something going wrong. Now, I can't even imagine skipping my appointments. I mean, I have no reason to, I'm not going to the other side of the city anymore. And for one thing, honestly, for what I have to pay for insurance, I might as well cash in on it…I can get free prescription prenatal vitamins so I don't have to pay for them. And I mean I have a doctor who really knows me, and who will really know my baby, and I really like that." (Interview, July 2017)

This time around, instead of choosing to preserve her finances, Mrs. P invests in the financial costs of healthcare, which she perceives to be more beneficial in multiple respects. Provider proximity, consistency, and familiarity are advantageous for her and her future child. The trade-off is flipped, thanks to a change in financial capacity. Indeed, financial cost is ultimately, the foundation of the affordability issue. From it evolve other notions of affordability which inevitably tie back to the informants' financial capabilities.

Time

For many informants, affordability, in relation to time is based largely on their personal and working lives. The monetization of time in relation to one's job regulated the activities of many informants. When I began working at the school in the summer, Mrs. W advised me to stay a couple hours extra every other day to help her grade and clean in order to get overtime pay. As

I graded spelling and math worksheets, she would impart, as she called it, "life advice" on me. She often told me how to make the most of my work schedule –"get the most bang for your buck"- especially, since I was a student. She worked for the school year-round and prided herself very much on getting paid during summer vacation, doing a job she loved. "I get paid sick days, but I like to save these for vacations –I mean I work all year." She also offered tutoring outside of school for younger students, teaching them how to read. She described her time dedicated to her two jobs monetarily, "My time….it's earned money." She implied that time spent not working, especially when one should be, is a cost, even when it comes to taking off of work for sick days, when they might be needed.

Like Mrs. W, other informants had occupations which offered paid leave but wanted to reserve this time for emergencies or vacations. Mrs. Z, as a single mother, tries to minimize the amount of time she takes off, for the sake of her daughter, after an incident in the previous year.

> "Last year, she was sick and I sent her to school. The school called me – she was throwin' up and had a fever but I had just started working at my job and I had bills to pay the next week, so I couldn't take time off. I couldn't go during my lunch break, because her school was too far. I called everyone I knew, my aunt had to go pick her up." (Interview, June 2017)

Her daughter who had come down with a bad stomach flu had to stay home for most of that week, but Mrs. Z was unable to stay home with her to take care of her. She expressed much regret and anxiety when recalling the situation but seemed prepared for the worst. Having taken only 1 sick day for herself since the incident and only taking off half-days for important errands after preemptively working overtime the days before, Mrs. Z maintains a nice and strategic safety net of paid leave.

> "I go to work even though I'm sick –I just feel like it's just better to have [my sick days], just in case you know. My daughter might get sick again –it might

> be worse. It might last longer…Like there are so many what if's, I'm just grateful my aunt can help me." (Interview, June 2017)

For Mrs. Z, her time is extremely valuable not only in its translation to pay, but also its transferability to her daughter's well-being. Though there were some informants who shared similar multi-faceted sentiments, the predominant valuation of time was monetary, especially during work days. Thus, when it came to medical appointments, rarely did they ever happen during the week when informants had work. Whether the appointments are for primary or prenatal care, they are nonetheless perceived as time-consuming and costly. Time and money taken to travel to a healthcare facility, see a provider, and if needed, go to the pharmacy, were ultimately, multi-fold financial losses: the loss of paid working time and money spent on transportation and co-pays.

Personal Health

The final notion of affordability, personal health, emerges as the most subjective version of this metric. The idea of affordability here is best captured by the question, "How long can I afford to go without seeing the doctor?" This question is posed during both periods of good health and illness. Informants often used the sentence, "I feel/felt fine," in order justify not seeking healthcare services, and thus, the point of not feeling "fine" was the point at which a healthcare provider was sought out, though what determines "feeling fine" varies among individuals. A pathology or symptom that is incapacitating for one person can be trivial to another. Though the scale of feeling "fine" to not feeling "fine" is unique for each person, it is consistent in that it is very dynamic, changing in response to stressors that range from financial to psychological. For example, many informants discussed reluctance to go to urgent care or a

local health center because of potential cost of services and wait time, deciding to instead deal with physical pain, take over the counter medication, or nurse themselves back to health. Indeed, there seemed to be a rather casual attitude around passing up health services, undergirded with the belief that problems would resolve themselves or become more bearable. Quite fittingly, the most extreme instance of this situation was one recounted to me during a party. Mrs. W and her daughter invited me to a monthly potluck held by her ministry, where I met Mrs. K, a close friend of her daughter. After being introduced, I joined their conversation, listening as they caught up and told each other stories from the past month.

When Mrs. W noted that I was returning to Penn that month for the fall semester, Mrs. K immediately threw her hands up, and exclaiming in disbelief that she had completely forgotten to share a hilarious anecdote. She had recently been admitted to the ER at Penn Presbyterian for a rather unfortunate mishap. She had accidentally left her contacts in makeup remover instead of saline solution overnight, while staying at a friend's. The following morning, when she put on her contacts, her eyes started burning. As they were making breakfast, she began to lose vision and her eyes were swelled shut. Despite trying to reassure her friend that she would be okay in an hour or so and did not need to see a doctor, her friend realized what happened and took her to the emergency room immediately. When I inquired about her reluctance to go to the hospital, Mrs. K explained,

> "I really thought it would go away on its own. Like I didn't want to get to the ER and be fine and then get charged. I mean like at first, I thought it was because I wore my contacts longer than I should have. I do that sometimes – they're the two weeks contacts. You know, it didn't seem too bad, like bad enough to go to the ER, but she kept saying 'We gotta go to the ER. We gotta go to the ER. You need to see a doctor' And I was like, 'No, no, no I know it's gonna go away, I just need to wash my eyes –or like them eye drops or something.' And finally she was like, 'B****, you are blind, I'm taking your Stevie Wonder-ass to the ER.' [Laughs]" (Interview, July 2017)

Though Mrs. K did not want to go to the emergency room, she considered herself fortunate that her friend made her go. The solution had severely damaged her cornea and so, she stayed in the hospital for 3 days, recovering from her blindness. Fortunately, going to the hospital was necessary. Her anecdote, which is highly amusing to her and her audience, conveys and normalizes a popular reluctance in seeking health services. The sharp juxtaposition of light humor and a serious health problem works to minimize concerns that may have been experienced in the moment and at the time of interview. That Mrs. K was initially adamant about not going to the ER for an objectively dangerous health issue, further emphasizes the reluctance for seeking preventative or active health services on a regular basis. Reluctance is a byproduct of the individual's sense of affordability of personal health grounded in her own capacity for pain or illness and further compounded by her willingness to spend money. The personal nature of gauging affordability is reflected by the strong juxtaposition between Mrs. K's reluctance and her friend's insistence to seek out help.

Much like anecdotes surrounding barriers stemming from issues of urban planning and affordability, Mrs. K's narrative reifies the point that barriers to "maternal health care services have to be contextualized within the broader comprehensive primary health care approach," (World Health Organization, n.d.).

The Healthcare System

Features of the healthcare system such as its bureaucracy and processes, act as barriers to access to maternal health care and resources. Bureaucracy surrounding health insurance and coverage makes it difficult for women to receive adequate perinatal care. In addition, invasive biomedical processes for facilitating good maternal health outcomes are inconsiderate of patient

needs. Both act as institutional forces ,which negatively impact maternal health outcomes in West Philadelphia.

The Bureaucracy of Coverage

Maternal health is a unique opportunity for utilizing the healthcare system. Pregnancy is a strong proxy for facilitating care, especially to those who have been unable to or have only had limited access. However, the main caveat to using care and resources is the ability to access them. Health insurance is one of many means of access. Insurance coverage often diminishes the costs of medical services or therapies, which ultimately, leads to better health outcomes (McCool, Guidera, & Janis, 2013). However, health insurance, let alone good health insurance, is not something everyone has. In 2015, following the ratification of the Affordable Healthcare Act, Pennsylvania governor Tom Wolf passed legislation to expand Medicaid in state, in an effort to decrease the number of Pennsylvanians who lacked health insurance coverage. According to the most recent data, approximately 6.8% of the state –down from 12.1% in 2010- still does not have health insurance coverage (Pennsylvania State Data Center, 2016). Philadelphia County has the second highest rate of uninsured persons at 9.7% (Pennsylvania State Data Center, 2016).

Among the portion of informants who disclosed their insurance coverage status, 11 had some form of consistent health insurance, 3 informants were on short-term insurance, and 2 were uninsured, at the time of their respective interviews. Though these numbers are neither reflective of the number of patients who are insured in West Philadelphia nor Philadelphia, the narratives surrounding them are far from unique. Many women often expressed anxiety or fear when discussing matters related to health insurance, spanning from the overwhelming nature of the

application process to the terrifying prospect of losing coverage. In the context of pregnancy, such concerns were magnified.

Mrs. T, a resilient veteran of these anxieties, explained to me that she was uninsured when she was pregnant with her first child. Unsure of what to do, she had been shocked and scared. Although she worked more than 40 hours a week, at the time, she still could not afford health insurance and did not think her salary would qualify her for Medicaid.

> "I was freaking out, you know –7 weeks pregnant, with no health insurance. I read so much stuff online, but I really didn't know where to start. I had remembered my sister done something with the "Healthy Beginnings"[vi] program and gotten Medicaid, but she had lost her job at the time. And I was workin' so I didn't know if I could do what she did," (Interview, August 2017)

Overwhelmed with information online, she was confused by the differences among Medicaid, COMPASS[vii], and Healthy Beginnings, not sure if they were all the same thing or if the latter two were even insurance at all. Her attempt to navigate the state's health insurance website left her frustrated and exhausted –"I was so confused, I wanted to cry. I just wanted to see a doctor and get checked up. I just wanted to know that everything would be okay," (Interview, August 2017).

Eventually, she received help from a social worker at a local welfare office who helped her apply for Medicaid through COMPASS and schedule prenatal appointments with Healthy Beginnings. Mrs. T recalled that although the process had been extraordinarily difficult at first, she had been extremely lucky with her timing, as she had enrolled in Medicaid before the open enrollment period ended. According to the social worker, her income did not qualify her for a year-round application for Medicaid, and thus, Mrs. T would have missed out on her opportunity to receive coverage. Federal and state programs such as Medicaid and the Children's Health Insurance Program (CHIP) that provide insurance coverage for low-income patients are often

based on income limits. However, these limits are often increased or become more flexible, when women become pregnant, making it much easier to qualify for coverage, especially for maternal health care (Belasco, 2016). Had she had not been pregnant, Mrs. T's income would have made it almost impossible to obtain coverage. Though she ultimately received insurance coverage, it took many weeks for her application to be approved and her proof of coverage –a Medicaid card- to arrive, thus delaying her in seeking health services, such as prenatal care.

Like Mrs. T, several of the other women who disclosed their coverage status had Medicaid. In fact, in Philadelphia many "maternity care patients rely on federally-sponsored Medicaid as their primary insurance…[with] approximately two-thirds of Philadelphia births being covered by government-sponsored medical assistance," (McCool et al., 2013). And, Mrs. T's arduous journey to coverage only reflects a few of the many ways in which "the bureaucracy of the healthcare system makes it difficult for women to understand that they qualify for coverage," (Belasco, 2016). In general, the application process itself is difficult to navigate as the paperwork is cumbersome and plenty. The process can feel overwhelming and if done incorrectly, futile, especially for women, who have low literacy, lack proper documentation, or do not have assistance like Mrs. T, who expressed to me: "I really did not think I would get insurance coverage…and I probably wouldn't have even tried to apply without [Social Worker]," (Interview, August 2017). In addition to the grueling process, regulations over the enrollment period can exclude women from coverage completely. Uninsured women, who do not qualify for Medicaid, with unplanned pregnancies or those who become pregnant outside of the open enrollment period of the federal marketplace, cannot enroll in federally-sponsored plans (McCool et al., 2013), as was almost the case for Mrs. T.

On the other hand, having and qualifying for coverage does not guarantee access. Though not the only reason, having to wait for eligibility and proof of coverage was frequently blamed for late or inadequate prenatal care. While she waited for her Medicaid card to arrive, Mrs. T had to reschedule the first appointment she had made at Healthy Beginnings.

> "Even though, the appointment was –I think, like two months away, when I first made it. I probably didn't get my approval until a week or so before my actual appointment date. And I called them to see if it was okay to go in without proof of coverage, but I was a new patient, so they wouldn't let me. And so, I had to reschedule to an appointment that was another two months away. I just remember being like, are you kidding me?" (Interview, August 2017).

Mrs. T's experience is not uncommon. Other informants revealed that they were not able to receive prenatal care until after the first trimester. Furthermore, across the nation, "waiting for Medicaid eligibility is among the most oft-cited reasons women give for not receiving prenatal care as early as they should," (Belasco, 2016). Though obtaining coverage may be a tremendous step towards increasing one's access to care and resources in the long term, the bureaucracy which surrounds insurance coverage can act detrimentally in the short term. However, in the case of maternal health, these detriments can have long-lasting impacts. Mothers who have late or no prenatal care are more susceptible to pregnancy complications, and their infants may have low birth weights, all of which have long term health implications (Martin, 2018).

Another barrier to access, which was described to be outside of Philadelphia but is still rather notable, is limited care options. Mrs. M, whose 35 year-old daughter lives outside of the city, expressed much concern to me about her daughter's insurance.

> "Her coverage is free, it's from the state, so you know, no co-pays when she goes to the doctor, gets medicine –anything. But that's pretty much it. There weren't a lot of places that took her insurance, and when they did, she had to wait months to get an appointment with anyone. I told her to move back to Philadelphia –I feel like there are more doctors in the city –more clinics. Maybe a little more places that would take her insurance." (Interview, July 2017)

According to Mrs. M, her daughter usually only receives care in community health centers or hospitals, which are widely notorious for being overcrowded or understaffed. Though her daughter does not pay out of pocket costs for health services, they are not as readily available or comprehensive as they might be in a private practice or with a specialist. However, seeking out such health services would prove to be very costly. Thus, the juxtaposition of complete coverage for limited care highlights other problems with bureaucracy that are related to insufficient funding, which are relevant to the healthcare delivery system in Philadelphia. Though there was a state expansion of Medicaid, which helped to significantly decrease the number of uninsured persons in Philadelphia, there was no corresponding increase in care and resources. In Philadelphia, the uninsured and Medicaid-insured populations of are largely serviced by the city's network of Federally Qualified Health Centers (FQHCs), a critical part of its healthcare delivery system. FQHCs are health centers identified by the Health Resources and Services Administration (HRSA) as serving "the most severely disadvantaged communities," (P. Brown, 2016), which is determined via a standardized score given to a geographic area or specific population. This identification allows health centers to receive funding from the federal government via competitive grants and enhanced Medicaid reimbursement rates, in order to remain affordable and open to medically underserved areas or populations. However, health centers must reapply for their FQHC status every year in order to receive this funding which can prove to be problematic for a number of reasons: 1.) demand for health services in existing health centers continues to outstrip available funds 2.) competition for grants is very fierce 3.) this competition disincentivizes the creation of new health centers in areas that may need more, such as West Philadelphia (E. J. Brown et al., 2015; Clay, 2011; McCool et al., 2013; Pennsylvania State Data Center, 2016).

Problematic Processes

Within the healthcare system, the processes considered crucial for facilitating good maternal health outcomes include a series of biomedical procedures and therapies, such as ultrasounds, amniocentesis, and physical pelvic and vaginal exams (ACOG, 2018; Martin, 2018; Montagne & Martin, 2017; Oladapo et al., 2017). However, these processes of care are very invasive (Montagne & Martin, 2017; Poslaniec, 2017). In West Philadelphia, where maternal health is colloquially understood as a personal matter, shared within a trusted community, these processes are especially, unconducive to the local nature of maternal health. The juxtaposing themes of intimacy of maternal health and invasiveness of health procedures were discussed by many informants, who felt uncomfortable with this discrepancy.

The invasive quality of health procedures is especially a problem for survivors of sexual, physical or emotional violence, who suffer from past traumas which they may not always feel comfortable disclosing to their providers. According to the US Department of Health, one in five women will experience a sexual assault at some point in their lives, and one in four girls will be sexually abused before the age of 18 (Poslaniec, 2017). A recent report on violence against women Philadelphia, where violence was defined as, “sexual assault and acts and threats of physical, sexual and emotional abuse by a current or former partner” (Sorenson, 2012) found that

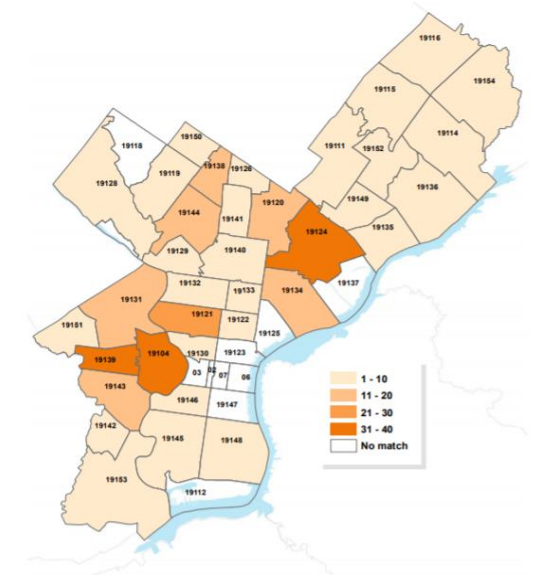

Figure 2.4 This is a map of the different health districts of Philadelphia which highlights rates of co-occurrences between domestic violence and arrests. *Sorenson, S.B. Violence Against Women in Philadelphia -A Report to the City. 2012.*

health districts in West Philadelphia had the highest rates of co-occurrences between domestic violence and arrests.

Granted these are not the only women who suffer from this violence, but it is a reminder that violence is an often underreported and thus, overlooked issue. Therefore, it is that much more important such caveats are regarded in the practice of women's health. This is especially the case for maternal health, where unresolved traumas are known to cause challenging complications in the delivery room from "labor dystocias to full blow anxiety attacks that result in a woman completely shutting down," (Poslaniec, 2017) that cannot be addressed with standard biomedical labor procedures. Even before going through labor, these traumas can inhibit women from accessing the care and resources they need, putting them at greater risk for poor maternal health outcomes.

Though she was not explicit in discussing her experiences, Mrs. Y, a mother of twin daughters, expressed discomfort with medical procedures, through her implicit wording and body language during our interview. She referred to a past incident which greatly impacted her ability to receive care, as it literally prevented her from seeing a provider.

> "I'm over it now, because it happened so long ago. And I've done a lot to be careful and be strong about it. But really, it's really hard to get over it. I remember, I just couldn't do it –my first doctor's exam after it, I was not okay. I couldn't even get changed out of my clothes. I was crying when the nurse came back in. I just told her I couldn't do it, and I think she understood. She told me that I didn't have to do anything I didn't want to do." (Interview, July 2017)

Though she was uncomfortable bringing up the topic, the eventual return to her poise and confident demeanor reflected her personal growth with the incident. She praised the nurse, who later provided Mrs. Y with a phone number to directly reach her and reschedule an appointment,

when she felt ready to come in. Mrs. Y acknowledged that, had the nurse not provided her phone number, she would probably not have later gone to see a doctor at all.

> "It was just hard to think about. I think, even though you're supposed to trust doctors because you know –they're supposed to help you. Once someone destroys your ability to trust, you can't trust anyone….It's hard to learn to trust again, but I think its possible." (Interview, August 2017)

The notion of trust Mrs. Y discussed strongly reinforces how intimate maternal health is and how sensitive maternal care needs to be. Procedures that are the standard of maternal health such as, and especially, pelvic and vaginal exams are physically invasive and can be very triggering for patients (Poslaniec, 2017; White, 2014). These caveats necessitate that providers be aware of non-verbal cues, facilitate understanding and consent, and tailor care, if needed.

Building trust with the patient is a way to acknowledge the intimacy of maternal health and minimize the impact of its invasive nature. Generally, trust was a common theme that was explicitly and implicitly mentioned by other women, throughout their interviews and in my observations of them, regardless of trauma history. For example, Mrs. S expressed a preference for female doctors, though she did not give me an explicit reason.

> "I didn't trust my first doctor. He was a dude, like why is a man a vagina doctor. I don't know seems weird, doesn't it? I didn't like it, so I left after the first appointment." (Interview, August 2017)

Because she did not disclose anything further, it is not my place to speculate her preferences under any circumstances. Rather I emphasize the significance of the role trust plays in accessing health care and services for informants. In recalling the social nature of maternal health discussed in the first chapter, trust is a key part of any social interaction, including those between patient and provider. However, for many informants, healthcare providers occupied the

farthest layer of their social support network, reflecting weak or impersonal relationships that could be a result of absence of trust.

Nevertheless, a lack of trust does not always imply distrust resulting from malice. Rather, for some informants, the driving force behind their lack of trust was simply a lack of opportunities to build it, because of the inconsistency and discontinuity in the providers they saw. Not seeing a face that they were comfortable with, having someone who was familiar with their medical history, and knowing who to expect as their doctor were all reasons cited for skepticism and hesitation in seeking care. Like Mrs. S, there were some women who decided not to return to their respective health centers or providers, such as Mrs. V, who found it difficult to build a relationship with her new provider.

> "I just don't like that I have to explain myself every time. I just want someone who knows what I need and who will listen to me. My old doctor, I loved her –but she left and the new doctor I got. I don't want to say it was because she was young or anything, but she was like 'Oh, I'm going to have you try this…" And I'm like no that's not what I need, but she's like 'Oh, yeah you should try this,'….I just left after that." (Interview, August 2017)

Both she and Mrs. S discuss leaving in the context of being dissatisfied with their provider and not wanting to return for appointments or health concerns. At the time of her interview, Mrs. V stated that she was still searching for a doctor she liked, while Mrs. S had found a female doctor she felt comfortable with. However, like Mrs. V, Mrs. S did not think she had a very personal relationship with her new provider, though she did not seem to mind as much. Given the variation between these two narratives, it is clear that regardless of the reason, the absence of trust is a very powerful barrier that can be difficult to overcome.

On the other hand, when trust is present, healthcare can be easily facilitated as patients are more engaged in the health system. Though it was more common for me to meet women who

were indifferent or reluctant to seek out care, I did meet Mrs. G, the only woman I interviewed who genuinely enjoyed seeing her doctor.

> "I love my doctor. She takes care of me and everyone in my family. We've been seeing her for almost 5, 6 years. I think maybe close to 6. The only times we don't see are when we go to my son's dermatologist, but he was recommended by her. They're like good friends. And we love him too." (Interview, August 2017)

In stark contrast to the previous women, Mrs. G is not only excited to see her provider but also trusts her, as shown by her enthusiasm regarding the dermatologist referral. Her relationship with her provider, which has been built over years of consistent appointments and care, is strengthened by her provider's personal engagement with her and her family.

> "She's just really sweet and nice, and you can tell she really cares about us. She'll take her time to ask us about how we're doing. She's always asking my son about school, you know 'How are you liking freshman year? Are you going to tryout for the basketball team?' because like my son has been playing league basketball…I don't know, it's just the little things like those I really appreciate." (Interview, August 2017)

In a space like West Philadelphia, where the maternal health experience is social and personal, the ability to make genuine connections and form personal relationships is greatly valued. This, along with trust, goes a long way in countering the invasive nature of maternal health procedures and encouraging patients to seek out care.

Section III: Facilitating Care -Reconfiguring Maternal Health

In this section, I examine how the understandings of maternal health as a personal and social experience amongst women in West Philadelphia have shaped their health-seeking behaviors. I argue that their reconfiguration of maternal health allows them to navigate and compensate for some limitations in their access to biomedical care. By utilizing care and resources from local social spaces, such as libraries and schools, and social networks, like family and friends, women in West Philadelphia attempt to combat poor maternal health outcomes.

Self-Care and Feeling Good in Personal Life

Whether it was my 6-year old students or informants, everyone I talked to always had something to say about their mother. Among the complaints of strict mothers, fond memories of shopping trips, and recipes of delicious home-cooked meals, there was no shortage of appreciation for women, who were described as enduring, accomplished, and compassionate individuals who gave all their love to their families and friends. Much like in other places of the world, the mothers of West Philadelphia take care of everyone in their lives. But, just as it is often asked, who delivers the mailman's mail? An important question arises: who takes care of the mother?

Well, the mother herself, of course.

Among women in West Philadelphia, maternal health is understood as their own health, regardless of a pregnancy and unconfined to obstetric concerns. Because the mother has the most

authority over her maternal health, maternal health care was often described care as "self-care." Although, the notion of self-care did include the practice of self-management of health, informants also contextualized self-care as a lifestyle practice likened to "treating yourself"[viii] or personal improvement. In midwifery literature, maternal self-care is understood as "the mother's ability (and willingness) to take care of herself both physically and emotionally. Proper nourishment, taking time out for one's self when necessary, attention to hygiene and physical appearance, adequate sleep, willingness to delegate and the ability to set boundaries are practical applications of self-care in motherhood," (Barkin & Wisner, 2013). For many informants, the goal of the practice of self-care was to "feel good," or reach a desired physical and mental state. Ultimately, this less medicalized understanding facilitated lifestyle choices and philosophies among women that were beneficial to their physical and mental health.

A Physical Feeling: Indulging in Healthy Lifestyles

One day in the summer, when the weather was particularly pleasant, I interviewed Mrs. C., a 4-month-old pregnant mother, who had just picked up her son from the day camp. We walked to the park across the street, where her son immediately left us to play on the jungle gym. She asked me how long the interview would take, and when I responded about half an hour, she asked if I minded conducting the interview while walking laps around the park with her.

> "I read online somewhere, a long time ago, when I was pregnant with [her son] that it's important to get some light exercise in when you're pregnant. Like not heavy exercise like running or sports, but like you know, walking or stretching or something. And you know, I like exercise anyway, it helps me destress. And you know that feeling you get after a good workout, like everything is sore but in a good way. I've been doing yoga for awhile and I love Blogilates[ix] –her videos! She's so cute. Anyway at least 30 minutes of walking is probably good… that's why I wanted to walk and talk, you know. Multi-task. Since you're asking me about what it's like to be a mom and all, this seems like a great thing to do. A great example," (Interview, June 2017)

Like Mrs. C, other informants pointed to a necessity for light exercise or some form of activity –"a walk around the block," is mentioned across several interviews- as a way of self-managing health. The benefit of light exercise is seen as twofold, for both the mother and the child. For the mother, exercise becomes part of a routine which would boost her physical health, in other respects besides her pregnancy. Additionally, being able to "destress" and "feeling …a good way," underscore the idea of self-care, that is both cathartic and healthy. One informant expressed taking a walk as an opportunity to "get fresh air", while others saw it as physical activity, which was generally good for their overall health. Subsequently, good overall health for the mother meant good health for the infant, among many informants, as Mrs. C explained, "if I don't feel good, I'm no good to anyone." As such, infant health was understood as a benefit of maternal health, as opposed to the purpose of maternal health.

"Eating right" was another activity in which numerous informants described practices of self-management of health, in the context of nutrition. A popular management technique was the omission or decrease of junk food and increase in fruits and vegetables in informants' diets. In the most extreme case of this, Mrs. F, the youngest woman I interviewed, who did not have any children, described a joint resolution she made with her coworker to go vegan for 3 months, following Beyonce's promotion of *The 22-Day Revolution*[x]. What began as a fun plan to "look good and feel good," eventually became a lifestyle change for her coworker, who found out she was pregnant approximately 2 months into their veganism endeavors. At the end of the 3 months, both resumed eating meat and dairy products. Mrs. F resumed eating chicken, because her mother often made chicken dishes for monthly family dinners. Her co-worker "would eat grilled or boiled stuff instead of fried chicken. She stopped eating hamburgers because they were greasy." Mrs. F admitted to reincorporating junk food like chips and pork rinds into her diet.

However, she noted that her co-worker continued a habit of snacking on apples and pears instead of chips and totally replaced milkshakes with fruit smoothies. This narrative strongly demonstrates the practice of self-care, through indulging in a healthy lifestyle. Mrs. F "feeling good," through her eating habits mirrors the pleasure that Mrs. C finds in light exercise.

Informants linked this idea of feeling good to alterations in other personal habits such as alcohol consumption, smoking tobacco and vaping, and drug use. A majority of informants agreed that these habits were detrimental to both maternal and infant health, especially to infant health during pregnancy. Some informants described a personal desire to mitigate these habits and eventually quit them during periods of non-pregnancy, in addition to dropping these habits during pregnancy. Of the three, smoking and vaping were described as the most difficult to quit.

> "I don't think of it as like quitting drinking or smoking weed. To me it was like the feeling, you know the feeling of being drunk, or tipsy, or like high. Like being fucked up. Feeling fucked up. I was like quitting that feeling, like that's how I thought of it. It was easier to quit that way…smoking a cig. It's not as easy, because I don't get high or drunk," (Interview, July 2017)

The notion of "feeling fucked up," starkly juxtaposes "feeling good," in regards to connotation and reference to health. However, the two strongly parallel each other, in terms of the perceptions that women have with respect to their bodies and health. The descriptive phrase, "fucked up," is emblematic of a demedicalized understanding of one's body. And the verb, feeling, is not confined to an emotional or mental state, that it is usually associated with, but rather informants incorporated a physical dimension relative to their own bodies. Herein lies the concept of the phenomenological body, elucidated by Scheper-Hughes and Lock, as "the lived experience of the body-self," (1987). For the women of West Philadelphia, their maternal health is largely shaped by their own sense of health and individual well-being, whether that is delineated along physical, mental, or both characteristics. However, as shown, this, for example,

does not mean bad health translates disease or illness for everyone. Rather, what is "good" and "bad" for an informant's maternal health remains fluid, abstract, and ultimately, defined by the informant, herself. The dynamic definitions are reflected in an individual's actions, of getting drunk, going vegan, or walking around the block, relative to how important or detrimental she perceives these actions to be to maintain her health.

In regards to maternal health, valuation of self-perception and practices of self-management of health, collectively compensate for the stresses felt by maternal responsibility. Much like Mrs. C, women in other maternal health studies "felt that effective mothering was contingent upon their own physical health," (Barkin & Wisner, 2013). In West Philadelphia, the lack of accessible providers for primary and maternal health care further underscores the need for self-care and consequently, "feeling good" that informants expressed. In the context of negotiating barriers to access, self-care was a means of compensating for limited resources, and perpetually "feeling good" was a way to avoid unnecessarily using these resources.

Feeling Feelings

In West Philadelphia, it is possible to feel good, in more ways than one. The single tireless sound that I heard every day I worked at the school, was the squeal of a delighted child. The high-pitched sound filled with glee, excitement and pleasure echoed resoundingly throughout the hallways of the school, and its happiness was contagious to anyone who hears it. Even outside of the school walls, it's enough to put a smile on anyone's face. In the park, as I walked around with Mrs. C, we both grinned at each other, as we heard her son cackling from the playground. "Someone's feeling really good," she shouted over at him. Her son ran up to us,

arms out, and she scooped him up into her arms, planting a kiss on his cheek. He giggled, slid out of her grasp and ran back to the playground.

Of all the feelings I have encountered in West Philadelphia and discussed, this final feeling is the most distinct because it is considered directly coupled and shared between the mother and her child, (i.e. if the child feels X, the mother will feel X, and vice versa) reifying the notion of their intrinsic connection in health. This feeling is also distinct in that it is explicitly emotional and contextualized in mental health, as opposed to a physical gratification. Mrs. C experiences both feelings, as she is satisfied with her exercise but also shares her son's euphoric mood, of "feeling really good." Along the same vein, other informants expressed their happiness, content, or excitement, in relation to a positive headspace. Though minimal in psychiatric contextualization, mental health, especially good mental health, was described by informants as a critical part of maternal health outcomes and the maternal experience. As a result, many mothers made active efforts towards feeling and maintaining positive emotions. This was especially the case for Mrs. O, whose partner died while she was pregnant.

> "I never seen so much blood before…. They took him to the hospital. All that blood –I couldn't think straight. I couldn't do anything. I tried to pray, but I couldn't. I think I just knew –all that blood, he wouldn't make it. Praying wouldn't put that blood back into his body. So that's why I couldn't pray. I couldn't think or do anything after that for a while." (Interview, August 2017)

She reflected on the months which followed the incident, describing the impact it had on her life. Guiding me through her grieving process, she shared her battles with mental health and eventual reconciliation of the event.

> "I made my peace with it. It was hard, but I did it. I did it for me, but I also did it for my baby boy. I found peace and happiness in myself because I wanted to love myself and give that same love to him. [Gestures towards her son] There is just so much hate and cruelty in this world. There's no point in bringing more of it into anyone's life. That's what I told myself to find peace again. No

> one deserves negativity. He needs love. He needs to be happy –and the only way that can happen is if I am happy too." (Interview, August 2017)

The association she made between her happiness and that of her son's strongly mirrors that of which I observed between Mrs. C and her son. This shared experience of maternal and child mental health demands an imbalanced effort on behalf of the mother to facilitate positive experiences for her child, while also maintaining her own mental health. In addition to Mrs. O, many other informants made an array of comments on this shared experience, underscoring their sense of responsibility they for the way their child felt.

"I always make sure [my son] has a reason to smile." (Interview, June 2017)

"If you are excited for your baby, it will feel that joy and love." (Interview, July 2017)

"My daughter's happiness comes first." (Interview, July 2017)

"I hurt, when my kids hurt," (Interview, August 2017)

On the other hand, experiences of sadness, frustration, or anger were linked to psychiatric challenges such as stress, anxiety or depression. However, anecdotes surrounding worries, negative emotions, or mental health struggles, were mostly recounted with humor –dark or good-natured, reflections on personal growth, or both. Such a practice reflected efforts made to maintain a positive outlook, reifying the perceived significance of sound mental health.

The nebulous nature of feelings –emotional and mental health- threaten to isolate one in her own mind, but efforts are made to socialize these feelings, whether good or bad. The strong association of mother and child demonstrate the sociality of emotional and mental health, a critical feature of their experience. An emotional experience is disseminated among women and those around them as seen by the collective excitement of Mrs. J's first pregnancy in the first section. Sociality of emotion is also demonstrated by the perceived emotional coupling between

a mother and her child, which also prompts the individual mother's active efforts to convey positive emotions or preserve mental health. Mrs. O strived to find happiness, following her partner's death, subsequently sharing her positivity with her son. Despite the greater emphasis placed on positivity, negative emotions and mental health concerns are not erased. Frustration, sadness, and stress are also shared experiences that can potentially be palliated by others. For example, physical, emotional or financial support from members of a mother's social support network can do much to alleviate her stresses or anxiety. Mrs. Z, who is often anxious or concerned about not being available for when her daughter might need her, is helped by her aunt who always offers to pick her daughter up from school, take her out on weekends, and cook for her. For Mrs. T, the frustration and stress surrounding her health insurance is affirmed by the social worker who kindly guides her through the Medicaid application process and schedule prenatal appointments. For the women who shared their anecdotes with humor and laughter, their use of laughter is a form of social expression. Especially, when it is considered in the context of pain, "it is a reminder that pain, too, is social. It distributes responsibilities, including to the pained subject," (Livingston, 2012). In addition to laughter, the personal reflections on past events or struggles evoke empathetic responses that served to validate pain felt and support healing. Thus, socializing sadness or happiness, frustration or satisfaction, stress or relief is a form of self-care, in its own way. In expressing –sharing, a personal feeling, it becomes a communal feeling, which serves to strengthen an individual's support system, in turn helping her. This positive feedback loop drives the understanding of maternal health as both a social and personal experience, among women in West Philadelphia.

Social Spaces and Systems of Care

In West Philadelphia, the social nature of maternal health contributes to the perception of social spaces as spaces of care amongst many women. Different social spaces correlate to layers in the support system, as it is in community and personal settings, where women can build and fortify their social support systems, which they directly link to maternal health. In addition, these places often provide maternal health resources and services for women, who might otherwise be unable to access the limited healthcare facilities in West Philadelphia. These reinforce the association that women have between their health and social spaces, which are sometimes deemed more accessible and amenable to maternal health needs.

Homes

Every month, Mrs. W hosts a W Family dinner in her home. Despite the name of the event, it is open to anyone who is invited. Each family member brings a different guest or guests to Mrs. W's small rowhome at the end of every month. No matter how many people are added to the guestlist at the last minute or show up unexpectedly, there always seems to be just enough space to fit everyone one and just enough food to go around. At my first W Family Dinner, I was content and stuffed with carbs, within the first 20 minutes, and I was more sleepy than social. However, everyone around me was chattering away at the news of Mrs. W's daughter-in-law's, Mrs. L's, second pregnancy. Mrs. W who has two children and three grandchildren jokes to me that she is an expert on babies. About a month before this dinner, she had expressed to me suspicions that she would soon have another grandchild. "I just got a feeling," she told me very nonchalantly, when I asked her how she knew.

Mrs. J had brought two big boxes to the dinner for her sister-in-law. The boxes were filled with prenatal vitamins, maternity clothing and shoes, and old pillows leftover from her last pregnancy two years ago. Her husband, Mr. J gave the expecting couple a matching stroller and bag set which he had bought as a spare but never used. A couple of older women in the room, including Mrs. J, impart some advice on Mrs. L, giving her recommendations for foods to eat, prayers to say, and routines to follow. Though this was Mrs. L's second pregnancy, the abundance of advice suggests that when it comes to being a mother, there is always more that can be done. Mrs. L graciously accepted her gifts and counsel, asking for recipes and phone numbers. This grand exchange is not unique to events like the dinner, but rather exchanges like these happen quite often and under much less formal contexts.

In fact, Mrs. W once told me that a pregnant woman's best friend was her own mother. When her own daughter was pregnant, Mrs. W gave her similar advice to that which Mrs. L received from the other women present at the dinner.

> "I told her that she better be getting rid of all the trash she was eatin' and start eatin' more fruits and vegetables. ….I also told her to make time for herself, because once the baby comes, it would be harder to make time…I told her to kick her coffee habit because caffeine was bad for the baby –she switched to tea. I gave her some books to read too, to her baby –I wasn't going to have no grandson who couldn't read,,"

Mrs. J later gave these books to Mrs. L, when she first became pregnant, along with a recommendation for a physician to visit for prenatal care, one she had gone to herself. These books, advice and recommendations were all given in passing or when one woman had visited the other. For example, Mrs. J initially received the books, when she picked up her mother to go shopping, and Mrs. L received the books when she dropped by Mrs. J's to pick up other maternal supplies. Likewise, many other informants discussed similar scenarios in of seeking out or

receiving resources from close female friends or relatives that they deemed vital or relevant to maternal health.

In addition to being destinations for these health-seeking behaviors, homes were often described as central locations for self-care for many informants. For some informants, this was due to people present in their homes, that they felt they could rely on for infant care. Mrs. P told me that her secret to a healthy motherhood run, so far was involving her husband in care. She would make her husband take care of the children, when she started to feel overwhelmed or fatigued. “I would just give him the baby, and tell him that I was going to take a nap, or call my sister,”(Interview, July 2017). In delegating work to her husband, Mrs. P utilized her support system to diminish her own stress and facilitate time for restorative activities.

Beauty Businesses

Outside of the home, women designated other social spaces as spaces of care. Bustling hair salons or vibrant nail shops were common destinations for informants seeking restorative activities. On a sticky Friday afternoon, I joined Mrs. L at her monthly hair appointment, in a cool beauty salon, in an attempt to escape the summer heat and her stressful week. Mrs. L, who was two months pregnant with her second child, at the time, had been coming to the salon monthly for the past half year, a twofold increase in her usual patronage.

> “I’m doing this for myself, because I know I won’t be able to in a few months. I mean it’s already pretty hard to do it now, because my schedule is getting crazier and crazier…This week was pretty crazy… I just come to relax and get back to a good place you know. Also, look good, feel good –that’s such a thing for me.”

Her hair stylist interjected, joking that Mrs. L’s children have kept her in business for the past few years. For Mrs. L, this monthly trip to the salon offered her an opportunity to destress

and relax from an overwhelming routine, allowing her to maintain her mental health. Other informants used trips to the salon as an opportunity to fortify or build their social support systems. For example, Mrs. J often went to the nail salon with Mrs. W and Mrs. L, where they would often talk and provide emotional support for each other.

It is at this point, that it is important to note that applications of self-care alluded to thus far, rely largely on "to varying degrees, the availability of time and other resources, such as help with child care and disposable income," (Logsdon, Hines-Martin, & Rakestraw, 2009). Though my informants provided great insight into local self-care applications, expanding my sociodemographic reach would have given much better perspective on the disparities in self-care applications. In their study on maternal self-care, amongst white, middle-class women in Pittsburgh, Barkin and Wisner talked to informants whose applications of self-care included shopping for nice clothes and shoes, attending gym or dance classes, and finding time to go out to a restaurant once a week (2013). Though self-care is a critical component of maintaining maternal health, it can be constrained or augmented by structural forces, external to the mother's control. Thus, recognizing these disparities is key to understanding that self-care applications may work to reduce poor maternal health outcomes, but these applications will not entirely resolve them. In West Philadelphia, though self-care empowers the mother to be proactive about her health, it is important to recall that she still faces the problem of having limited means to do so.

The School

The most literal example of a community space doubling as a space of care would be Sayre High School, whose campus houses Sayre Health Center, a small FQHC serving patients

across various neighborhoods of West Philadelphia. When I initially began my project there, I found that Sayre Health Center had a number of outreach strategies oriented towards improving clinic publicity and ultimately, community health. The center offers activities open to the public including daily exercises classes where attendance is incentivized with gift cards, nutrition-focused African cuisine cooking classes, and health curriculums for youth. Every year, the center provides free flu vaccinations during the high school's Back to School Night in the fall and hosts a health fair for the community in the spring. Such programming serves to engage local participation in social networks and facilitate community health. That Sayre Health Center and Sayre High School occupy a common physical space reifies this synergistic endeavor. However, even without the health center, Sayre High School and other local high schools, were understood as maternal health spaces.

Such a perception existed especially in reference to younger pregnant women who were students in high school. Although I did not interview any pregnant students, some informants shared anecdotes about former classmates. In particular, Mrs. U, one of the younger women I interviewed, had a close friend, V, who was pregnant throughout their senior year of high school. They remain friends to this day, and V, who now has two children, has since moved to a neighborhood in North Philadelphia. Mrs. U remarked that it was, in fact V's pregnancy which strengthened their friendship. "She always tells me that I was there for her during [her pregnancy]. I mean we've been friends since like elementary school, she's basically my sister," (Interview, July 2017) she said to me, as she pulled up a picture on her phone, of an old photograph of her and V as young girls. Given the nature of their friendship, it is clear that she was critical person in V's social support system. She provided strong emotional support for V,

which Along the same vein, there were other individuals that Mrs. U described, affiliated with the school who were a vital part of V's social support system.

> "Mrs. X, the vice principal was the one –she really watched out for [my friend]. V told me that she was one of the first people to know she was pregnant. Apparently, she saw V throwing up in a trash and brought her into her office. I remember V told me she was kind of in denial up until that point, and she just cried in her office. I can't even imagine…. It's so funny because I think –I thought. Well, we all thought that Mrs. X was just kind of an uptight bitch but she was so nice and caring to V. She put V up in the teen mom programs that we had at the school. She had to do like health classes, and adult school after school because she had to skip school and stuff [because of her pregnancy]." (Interview, July 2017)

In addition to the vice principal, Mrs. U explained that their entire friend group was very supportive of their friend V, defending her from bullies, accompanying her to clinic visits on the weekends, and bringing her notes or assignments from classes she missed. She noted that V also found friends in some of the other pregnant teens at their school who were in her health classes. Their collective experiences allowed the girls to connect, bond, and ultimately, be a part of each other's social support.

> "I remember V showed me a MySpace group they made for themselves. And they just used it to talk about stuff –like mom stuff, school stuff….Like they'd post these pictures of things they were doing and write these like bulletins and stuff. I think the group even had some older girls who already had their kids and graduated and stuff. [The older girls] were really encouraging….I thought it was pretty cool." (Interview, July 2017)

This narrative shows the impact of the school-based classes. The social support which is founded in the physical space of the school, expands into external and more abstract spaces, like the Internet. Further reifying the school as a health space is the purpose of the health classes themselves. These classes served to provide the young women information about what to expect during their pregnancy, resources for prenatal care, and topics, like nutrition and exercise,

important to maternal health. Instructors were often nurses or social workers, which strengthened the parallel of the provision of health information in this school setting to that one would find at a doctor's office.

The Library

Likewise, local public libraries often offer general health programming, ranging from educational workshops to miniature clinics, which occasionally offer maternal health resources. The Free Library Network has various locations around Philadelphia, all of which offer health programming on a consistent basis. The Lucien E. Blackwell West Philadelphia Regional Library offers several health programs every month that range from HIV/AIDS workshops to nutrition classes. In terms of maternal health, a recent grant from the American Academy of Pediatrics & Life House Lactation & Perinatal Services has enabled a biweekly breastfeeding awareness and empowerment program. Through this program, parents are able to meet and connect with other breastfeeding parents, effectively constructing their social support system. Additionally, the program is educational in that it offers the latest breastfeeding information from a breastfeeding health expert. The program also provides participants with free breastfeeding supplies, food and travel compensation.

Although only a few informants had been to these workshops, none were regular attendees, often citing that the programming would switch between being held on Saturdays and Fridays, a working day. However, many informants discussed taking advantage of other health programming, such as sexual health and nutrition classes, which were often led by health professionals, ranging from nurses to nutritionists, though not always providers. Given the variation in topics and dates for the health programming, most informants did not go to the

library on a regular basis and only attended health workshops based on interest or availability. Thus, unlike the space of the school, the library was less explicitly associated with facilitating maternal health through social support. It was generally perceived as a place which provided important health information and sometimes, care, though not always related to maternal health. However, the wealth of general health information the library offers easily facilitates its reputation of a health space for many informants. Mrs. E and her boyfriend are loyal patrons of the health programming offered at the local library, which is about a block away from their apartment. They have attended workshops on making first aid kits, gotten their blood pressure checked, and learned how to read nutrition labels on food packaging. Despite her interest in the programming, Mrs. W lamented the limited programming on maternal health.

> "My boyfriend and I was there when they did a class on healthy eating. We thought the nurse that came to help teach seemed pretty helpful, but she couldn't stay –like she left halfway. He said to me we should go to the next one and try to talk to the nurses after and ask some questions. Because I had some questions about going to the doctor and my baby, like questions about what I should be doing, and also my mom had had something with her pregnancy. So we went to the next one we could, and it was on HIV and AIDS, and the nurses weren't the same as the last time. I can't even remember if the people teaching the class were nurses. Because I asked my questions but they kept telling me that they didn't feel like they could help me enough you know. And I don't wanna pay to see a doctor just to ask questions."
>
> "Do you think classes on prenatal care or more classes on maternal health at the library would be helpful?"
>
> "Yes definitely. I think like there are other health questions people have that they should be able to know about, you know," (Interview, July 2017)

This narrative fully reflects the way in which the library is seen as a catch-all resource for health information. Despite the specific topics of the programming, Mrs. E and her boyfriend have expectations for finding general health expertise at these workshops. Though their expectations are not met, they still maintain the perception of the library as a health space, insisting on the expansion of the health resources it offers. This association between the library

and health is something the University of Pennsylvania has attempted to tap into and further, by partnering with local Philadelphia libraries, in an effort to address population health and social determinants of health (Butler, 2017; Morgan et al., 2016). Through this partnership, librarians were trained as community health specialists and health programming was created for a wider range of ages and socioeconomic backgrounds. In an evaluative study, researchers found that in 2015, “almost 10 percent of the libraries’ 5.8 million in-person visitors accessed specialized programs and assistance in such areas as nutrition, trauma and mental health resources, and healthy behaviors,” (Morgan et al., 2016). Currently, the library’s quality of accessibility, as a community space, makes it ideal for connecting a wide array of visitors with services and help. Moving forward, it can to be potentially viable avenue for distributing maternal health resources and care, reaching women who perhaps need them most.

Conclusion

Through this thesis, I have sought to demonstrate how women seeking maternal health care in West Philadelphia are at times excluded from the healthcare system by various social, economic and political barriers. These barriers are mediated by a local reconfiguration of maternal health, which allows women to find care and resources. I analyze normative conceptualizations of maternal health shaped by biomedical discourse against the descriptive conceptualizations of maternal health that emerge from the women of West Philadelphia. This juxtaposition demonstrates a vast disparity between normative health system –inclusive of providers- expectations and patient realities of maternal health. I unpack challenges surrounding access to care, including poor urban planning, lack of affordability and institutional characteristics of healthcare. I also examine the means through which women negotiate their circumstances and empower their own provision of maternal health care in West Philadelphia.

This research aims to provide more context and anthropological insight into inequities surrounding the nebulous inequalities in public health data on maternal health outcomes in West Philadelphia. Discrepancies between providers and patients in regards to understandings of maternal health related needs and care implicate a trend of medicalization of maternal health in the interest of infant health. This reveals the lack of structural support from medical institutions for new mothers. Furthermore, socioeconomic and institutional barriers to care and resources for general health engender greater difficulty in accessing more specialized care needed for maternal health. Though there is an informal and fragmented health system in place to navigate these challenges, it is not enough to fully compensate for the systemic exclusion. The problem of maternal health in West Philadelphia shows the plight of women who are recognized by institutions of healthcare and medicine but simultaneously subject to them.

That being said, the women of West Philadelphia, may only represent a small portion of the population of mothers facing maternal health challenges, but that does not in any way discount their experiences. It would be a fair assessment to say that the findings of this research are applicable to motherhood and maternal health in general. However, as I asserted in my introduction, the dangers to maternal health, in many places, may be more pronounced than others due to larger forces of structural violence. And as shown, in West Philadelphia, maternal health challenges are exacerbated by a dangerous synergy of various structural issues on multiple levels: community, city and state, and system. At the community level, West Philadelphia, issues include poor urban planning, low provider availabilities, high incidences of violence against women and poverty. At the overall city and state level, problems include lack of updated data on maternal health and unevenly distributed care and resources. And finally, bureaucracy, impersonality, lack of affordability and racialization of care are larger systematic issues which stem from medical and socioeconomic institutions, everywhere. These compounding forces serve to diminish the quality of maternal health outcomes in West Philadelphia.

In the same way, it is the unique accumulation of the very women of West Philadelphia that empowers the community's social support and informal health systems. It is their unique experiences and relationships which allow them to create a system of care which can work for them. There is no doubt that social support plays a role in other communities as well. However, what sets each community apart is not how strong or how effective their systems are but rather the group of individual women who bring their stories, compassion, and strengths to the table. Thus, maternal health in West Philadelphia and maternal health in general should not be treated as mutually exclusive, and the findings of this thesis should be viewed as such. Local

manifestations of larger issues can be great starting points for developing solutions that would equitably address health inequalities.

As with any study, there were limitations in my research that I hope to address through future work. Though my position at the school greatly facilitated my research, my sampling was largely constrained to women affiliated with the school. This was limiting in a number of ways. The school itself is a private school with tuition that would likely exclude families with lower income levels and socioeconomic statuses. There were a number of students at the school who were on financial aid scholarships, however I did not know who and specific names were never disclosed to me by any of the staff. Furthermore, the private school was affiliated with a church and included religious studies in its curriculum. This implies that the families of students enrolled at the school were likely a Christian denomination. The sampling population likely excluded women who were not religious and did not have a social support network maintained through a religious organization. Though some women who were interviewed did not have health-seeking behaviors, these qualities of the school ultimately limited sampling of women who would face greater barriers to maternal healthcare access and worse economic and psychosocial stressors. Another limitation was the geographical delineation I drew in my research. The geographical region of West Philadelphia to which I confined my discussion of urban planning related barriers covered less than half of the actual expanse of West Philadelphia, which likely excluded critical challenges faced by some women I interviewed who cited having a commute to the school of over an hour, indicating that they perhaps did not live in that area of study.

Nevertheless, not only do these limitations present new directions regarding future research, but they also provoke thoughtful questions to re-examine the state of maternal health

care. In West Philadelphia, the construction of maternal health as a personal and social matter implicates the need for a more community centered approach to care that considers general well-being. Many lessons can be learned from patient realities that can ameliorate healthcare delivery and thus health outcomes. The inequities faced by women in West Philadelphia undoubtedly inhibit maternal health outcomes for other women around the world. There is an urgent need to find ways to address institutional barriers to maternal health, improve socioeconomic conditions of women, and facilitate equitable distribution of care and resources. This means challenging the status quo of global health, which juggles various moral and political economies, for the sake of expanding democratization of healthcare.

Acknowledgements

Thank you to my mother, an amazing role model from whom I draw my inspirations and passions for everything that I pursue. I am also immensely appreciative of all the faculty and staff of Anthropology Department who have provided me with incredible opportunities to learn and grow. I would like to thank Dr. Megan Kassabaum and Dr. Puneet Sahota, both of whom drew me into anthropology as an underclassman, with their inspiring work and engaging mentorship. I am grateful to Dr. Morgan Hoke and Dr. Michael Joiner for pushing me to complicate and expand my understandings and practices of medical anthropology. I would like to thank Dr. Katherine Moore and Dr. Adriana Petryna for their patience and understanding throughout this process. But especially, I would like to thank Dr. Kent Bream and Dr. Fran Barg, both of whom first encouraged me to pursue this project my sophomore year, which has come to define much of my undergraduate research career.

Most importantly, thank you to all the women who welcomed me into your lives and shared your experiences with me. Your time, trust, and stories mean the world to me, and this project would not have been possible without you.

Let motherly love endure.

Endnotes

[i] Reading now about this shift is reassuring in many ways. The first is that I feel a bit better about the archival research I had conducted at the time, because I thought that there was data that I was not accessing due to my amateurism as a researcher, but as it turns out I was not in fact missing out on data because very little existed at the time.

[ii] This study excluded the neighborhoods of University City and its affiliated areas, in an effort disaggregate information to better represent disparities that would have otherwise been diminished by skewed data.

[iii] All the names of informants have been changed to protect their identities. The use of the title Mrs. does not imply the marital status of the informant. Rather this particular style of naming was chosen as it parallels the way in which students addressed the staff at the school.

[iv] These two areas of Los Angeles are comparable to parts of West Philadelphia in regards to socioeconomic demographics such as median income and race, in addition to their inner-city reputations in pop culture.

[v] The Family and Medical Leave Act allows eligible employees of covered employers to take unpaid, job-protected leave for family or medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave. For pregnancies, this leave is covered up to 6 weeks (U.S. Department of Labor, n.d.).

[vi] Healthy Beginnings is a state program which provides services for women's psychosocial, traditional medical, and obstetric needs to low-income, pregnant women who are eligible for Medical Assistance, or Medicaid.

[vii] COMPASS is an online tool for Pennsylvanians to apply for public assistance programs in health and human services, i.e. healthcare, school meals, etc.

[viii] The action of treating yourself is likened to indulging. In some contexts, it is seen as indulging for reasons of self-compassion or reward.

[ix] Blogilates is an Internet personality, Cassey Ho, who is known for her fitness and lifestyle videos on Youtube.

[x] The 22 Day Revolution is a vegan diet that was endorsed by Beyonce in 2015.

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